“APRE BONDYE SE DOKTE [AFTER GOD IS THE DOCTOR]:” PERCEPTIONS OF PROVIDER-PATIENT RELATIONSHIPS IN POST-EARTHQUAKE HAITI

by

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Abstract

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The destructive earthquake of January 2010 in Haiti led to an inpouring of health care professionals onto the island. The purpose of this qualitative study was to explore with a sample of patients and health care professionals, in the US and in Haiti, their perceptions of receiving or giving care in Haiti since the earthquake. Although there have been many anecdotal reports on the experiences of health professionals, mostly foreign, delivering care after the earthquake, there have not been any investigations of the quality of relationships developed between Haitian patients and the myriad of health care providers presently delivering health care in Haiti. In this study, I hoped to shed light on the experiences, perceptions, and beliefs of providers and patients in a critical time of health care reform in post-earthquake Haiti.

This study was guided by the qualitative data-gathering and data-analyzing processes of *Grounded Theory.* In-depth semi-structured interviews, both group and individual, with a total of 46 participants were conducted. The study was conducted in two phases, with the first phase held in a northeastern state of the United States, and the second phase conducted at three medical sites in Haiti. Findings from the study offer insight into providers and patients’ perceptions of each other, in addition to participants’ beliefs about illness and healing methods. Data on participants’ perceptions of health services since the earthquake are also presented. Implications and recommendations for health care practice and training are suggested.

DEDICATION

To my family, *you* are the reason for it all.

"My mother prayed for me,
had me on her mind,
took the time to pray for me,
I'm so glad she prayed…,
I'm so glad she prayed for me."

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ABBREVIATIONS AND KEY TERMINOLOGY

Departments	Regional areas of Haiti
ISAC	InterAgency Standing Committee
MSPP	Ministère de la Santé Publique et de la Population [Ministry of Health]
NGOs	Non Governmental Organizations
NHAHA	National Haitian American Health Alliance
OCHA	Office for the Coordination of Humanitarian Affairs
PAHO	Pan American Health Organization
WHO	World Health Organization

Chapter One: Introduction

Problem Statement

The destructive earthquake of January 2010 in Haiti led to an inpouring of health care professionals onto the island (PAHO, 2011). In 2010 alone, 400 international agencies organized themselves to provide medical assistance to injured earthquake survivors (OCHA, 2011). It was reported by many that the earthquake further weakened a health system that was struggling to function prior to the destruction (PAHO, 2011; NATO-Harvard, 2012; Farmer, 2011; Sontag, 2012). As was reported in the media immediately after the quake and more recently in the growing literature on health services in Haiti, health care providers were overwhelmed by the significant obstacles (lack of infrastructure, cultural differences, and the complex socio-political climate) in meeting the immense needs of injured earthquake survivors (Pierre-Pierre, 2010; Miller, E., 2010; Bayard, 2010; Rhea, 2010). Anecdotal reports suggest that in spite of challenges, patients were greatly appreciative of the basic services received from health professionals (Bailey, Bailey, & Akpudo, 2010; Etienne, 2011; Bratten, 2010; Ricciotti, 2010).

Presently, three years after the earthquake, the country's Ministry of Health (MSPP), other international governments and agencies, and the thousands (Pierre-Louis, 2011; PAHO, 2011; Schuller, 2010) of non-governmental organizations (NGOs), whose contributions in Haiti before and after the quake have been thought to supplement the shortages within the Haitian health care system (Farmer, 2011; PAHO, 2011; Sontag, 2012), are moving forward in reforming the current health care structure (PAHO, 2011; MSPP, 2010). However, problems with establishing an efficient system have surfaced throughout this process (PAHO, 2011). Among the many problems, competition for financial support among foreign health professionals, native

Haitian practitioners, and practitioners from the Haitian diaspora returning home has been noted (PAHO, 2011), all to the detriment of Haitian patients.

As these entities prepare to reestablish a more efficient and sustainable health care system, there is a dearth of empirical explorations on the quality of health services in Haiti. Not much is known about the experience of health care providers and patients giving and receiving care in the pre or post-quake health systems. Although there have been many reports on the experiences of health professionals, mostly foreign, delivering care after the earthquake, there have not been many investigations of the relationship between Haitian patients and the myriad of health care providers presently delivering health care in Haiti.

In a country known for its people’s traditional practice of herbal medicine and varied beliefs in the causes of illness (Culture Vision, 2010; Farmer, 1990; WHO, 2010), in addition to the well documented complexity of Haiti’s history and social climate, it is imperative to understand the relationships among Haitian patients, foreign health care providers, and Haitian health care providers in the health care system. In this study, the experiences, perceptions, and beliefs of providers and patients in a critical time of health care reform in post-earthquake Haiti were explored.

Statement of Purpose and Research Questions

The purpose of this qualitative study was to explore perceptions of interpersonal relationships between Haitian, as well as non-Haitian, health care providers and Haitian patients. In addition, I aimed to better understand beliefs about illness and traditional healing methods practiced and endorsed by participants. Before data collection, the following guiding questions were posed:

1. What are Haitian, as well as foreign health care providers,' perceptions of Haitian patients?
2. What are Haitian patients' perceptions of foreign health care providers, compared to native Haitian health care providers?
3. How do beliefs about the causes of illness, models of health care interaction, and traditional healing practices affect provider-patient relationships?
4. What other factors within the provider-patient relationship affect patients and providers' perceptions of health services?

The Researcher[1]

I was born and raised in the United States by two Haitian parents who emigrated from the southern provinces of Les Cayes and Jacmel, Haiti in the early 1980s. A considerable number of my maternal and paternal relatives still reside in Haiti. My family was quite fortunate to not have lost any relatives or friends during the earthquake.

Prior to the earthquake, I had spent many family vacations since the age of 11 in Haiti, with the most recent visit being exactly one week before the earthquake in the country's capital of Port-au-Prince. Determined to return to Haiti after the earthquake to assist with relief efforts, I became involved with various professional Haitian organizations in Philadelphia, New York, and Connecticut. One month after the quake, I sought training in international psychosocial intervention offered by the affiliate InterAgency Standing Committee (ISAC) of the United Nations (UN). I was also interning with the American Psychological Association NGO

[1] Presenting the researcher's background as it relates to the topic of study clarifies the perspective from which the researcher conducted this study, as well as stages the potential bias in data collection and analysis methods (Charmaz, 2006; Fontana & Frey, 2003).

Committee (APA NGO Committee) at the UN during this time and observed directly the mobilization and response of psychologists at the UN to the earthquake.

Approximately one month after the IASC training, I traveled to Haiti in March 2010 with medical volunteers from two Haitian professional organizations from which participants were recruited for the first phase of this study. Alongside the nurses on this team of health professionals, I assisted prosthetists with translation and provided mental health support for amputees at a community hospital in the Port-au-Prince area for one week.

In October 2010, I returned to Haiti to attend a conference sponsored by the National Haitian American Health Alliance (NHAHA) and the Haitian Ministry of Public Health and Population (MSPP) on Haitian health and mental health needs. While attending the conference, the first cases of cholera were reported in the Artibonite department[2] of Haiti.

In October 2011, I became involved with the *Chancellor of The City University of New York's Haiti Initiative* (CUNY Haiti Initiative). Among other roles, I co-developed and co-led a two-week seminar in community health at a regional public university in Les Cayes, Haiti, with an interdisciplinary team of four CUNY professors and alumni.

Rationale and Significance

The rationale for this study emerges from the need to better understand the quality of health care delivery in post-earthquake Haiti, as the Haitian government and the international community moves to rebuild the health care system. The existing literature on factors contributing to the quality of health services suggests that the provider-patient relationship is an important aspect of perceived quality of care (Sofaer & Firminger, 2005; Flocke, Miller, Crabtree, 2002). Given the mix of foreign health care providers, Haitian medical practitioners

[2] Haiti is administratively organized into ten regional areas called *departments*. The ten departments are Artibonite, Grand'Anse, Nippes, Nord, Nord d'Est, Nord d'Ouest, Sud, Sud Est, Ouest, and Centre (MSPP, 2010).

from the diaspora, and native practitioners presently in Haiti, the question, “What aspects of the provider-patient relationship affect perceived quality of care?” is pertinent, as this diverse group of health professionals may represent a wide range of beliefs on health care practice. Many studies have addressed concern about the violation of medical ethics during the emergency response phase and some authors have penned sincere pleas for attention to the human rights of patients in providers’ practice (Ouyang & Gruskin, 2010; Van Hoving, Wallis, Docrat, & DeVries 2010; Jobe, 2010). However, there has not been any investigation of the Haitian patient’s perspective on receiving health services, and particularly, what the patient deems integral to the provider -patient relationship.

Guided by the research principles and methods of qualitative research, particularly the approach of *Grounded Theory*, the experience of giving and receiving health care among a sample of Haitian patients as well as Haitian-native and foreign health care providers were explored. The aim of this study was to gain more insight into the question above and to the previously mentioned primary research questions to assist in informing the training and practice of health care providers in Haiti.

Chapter Two: Review of Relevant Literature

Introduction

This chapter begins with a review of the literature relevant to the study topic. Firstly, the events of the 2010 Haitian earthquake are presented, followed by information about the health care system in Haiti prior to the earthquake. The international medical response after the earthquake, the barriers to repairing the present healthcare system, and the importance of provider-patient relationships in assessing the quality of health services are also reviewed. Finally, Haitian models of illness and practice of traditional medicine is discussed.

The Earthquake

The Haitian earthquake of January 2010, now referred to as “goudou- goudou” by Haitian natives, further destabilized a country that ranked low, 145 out of 169, in the Human Development Index before the earthquake (OCHA, 2011a). “Goudou-goudou” refers to the sounds of loud rumbling noises that were heard as hospitals, churches, commercial buildings, and homes came tumbling down in Leogane, Port-au-Prince and Jacmel. Although lasting a mere 35 seconds (Bellegarde-Smith, 2011), the earthquake, whose epicenter was in Leogane, brought great grief to the small nation located on the western half of the island of Hispaniola in the Caribbean. Once affectionately known as “La Perle des Antilles [The Jewel of the Caribbean]” (Pierre-Louis, 2011), Haiti suffered from substantial political, economic, social, and agricultural ailments prior to the *goudou-goudou* (PAHO/WHO, 2006). It is estimated that up to 300,000 Haitians who were in the affected areas at the time of the earthquake either died or were injured (PAHO, 2011) and 1.5 million people were displaced from their homes (Schuller, 2010). According to a recent report on internally displaced persons (IDPs), approximately 360,000

people remain in IDP sites across Port-au-Prince and sorounding quake-affected neighborhoods (IOM, 2012).

While there is an urge to blame the 7.0 magnitude of the earthquake for the massive destruction witnessed and endured on and after that Tuesday afternoon, it is more accurate to examine and hold accountable the inefficient governmental systems and social strife that existed in Haiti before the earthquake. Bellegarde-Smith (2011) contends that it was a "man-made disaster" produced by an unconcerned government that failed to develop and enforce existing regulations for building construction. Due to policies developed between the mid to late 1900s, during the dictatorships of father and son Francois and Jean Claude Duvalier, poor and unemployed citizens were forced into the inadequate construction of "shantytowns" for shelter (Dubois, 2012; Schuller, 2010).

Yamin (2010) also argues that the damage was due to an absence of environmental policies, in spite of years of earthquake warnings for the country (PAHO/WHO, 2007). Haiti faces widespread deforestation coupled with a natural threat for hurricanes due to the country's geographic location (CIA, 2011). Dubois (2012) dates the beginning of deforestation to European colonizers pre-independence practice of chopping wood to be sold in Europe, although presently it is often attributed to the rural population's practice of chopping wood for charcoal (Oliver-Smith, 2012).

In 2008 alone, Haiti was burdened with four hurricanes (Morris, 2010). This created a recipe for a perilous environmental context, often resulting in landslides, flooding, massive deaths, hunger, and homelessness after hurricane season (Morris, 2010). Both Bellegarde-Smith's and Yamin's arguments resonate, especially when comparing Haiti to more developed countries like Chile and Japan. These countries also experienced earthquakes shortly after Haiti's

earthquake, although of greater magnitude yet suffering much less devastation. Schuller (2010) also argues that Haiti was in a much more vulnerable position economically before the earthquake compared to Chile.

Kidder (2010) supports the notion that a significant lack of infrastructure and policies set the stage for the earthquake damage. Kidder criticized the Haitian and US governments and nongovernmental organizations (NGOs) for failing to do more about the dire poverty before the earthquake. He argued that the country's unpreparedness for such a disaster was a reflection of the greater problem between private sector aid groups and governments that have opposed collaboration amongst the entities. Specifically, NGOs have chosen to work parallel to the Haitian government and not in conjunction with the government, resulting in a lack of transparency and accountability among organizations that are estimated to have increased their presence in Haiti dramatically since the earthquake (Pierre-Louis, 2011).

Health and the Health Care System before the Earthquake

Before the earthquake, Haiti ranked highly for maternal and infant mortality. HIV/AIDS affected men, women, and youth, with prevalence rates around 3%, the highest in the western hemisphere (PAHO/WHO, 2006). The incidence of malaria increased drastically after the quake, increasing from low risk rates to almost a 47% chance of risk in the town of Leogane (Neuberger, et. al., 2011). The circumstances for children were found to be even more dismal. Twenty-five percent of children suffered from malnutrition and 15% of newborns were underweight at birth. Diarrhea and respiratory problems accounted for 50% of the death of children under the age of five. It was also estimated that less than 25% of infants were delivered by qualified health professionals (PAHO/WHO, 2006).

Prior to the earthquake, 47% of the population did not have access to healthcare (PAHO/WHO, 2007). Health services were centralized in Port-au-Prince, the capital city of Haiti, and only 2.5 doctors per 10,000 people were available to deliver care (PAHO/WHO, 2006). The healthcare system composed of a variety of healthcare professionals employed in the public, private, nonprofit, and traditional sectors (PAHO/WHO, 2007). Although the country's Ministry of Public Health and Population (MSPP) is the designated coordinating body for all health care affairs, MSPP was unsuccessful in regulating the activities of the significant portion of professionals in the private sector. The nonprofit sector was mostly comprised of NGOs and members of MSPP. This contributed to the inaccessibility of healthcare, as these low-cost facilities were located mostly in urban areas (PAHO/WHO, 2007). While public services were inaccessible, private health services were unaffordable, 80% of the general population was estimated to have relied on traditional healing methods. With less than 1% of the Gross Domestic Product (GDP) being spent on healthcare, public sector facilities were plagued by frequent employee strikes and an overall lack of resources to deliver basic care (PAHO/WHO, 2007).

The International Medical Response after the Earthquake

Haiti received a tremendous international medical response after the earthquake. Given the crippling effect of the earthquake on the Haitian government- specifically killing 90% of the Haitian ministry of health's staff (Jobe, 2010), medical teams were deployed from many international governmental and nongovernmental agencies to compensate for the substantial loss. The United Nations (UN), which already had a peacekeeping mission in operation, the United Nations Stabilization Mission in Haiti (MINUSTAH), activated its system of disaster response agencies for the quake. These agencies included the United Nations Children's Fund (UNICEF), the United Nations Office of Coordination and Humanitarian Affairs (OCHA), the Pan American

Health Organization of the World Health Organization (PAHO/WHO), and the United Nations Development Programme (UNDP) (McIntyre, et. al., 2011). It is estimated that 10,000 nongovernmental agencies were operating in Haiti before the earthquake and this increased significantly after the earthquake (Pierre-Louis, 2011). Cuban medical professionals alone increased their presence from 500 to 1300 healthcare providers in Haiti (Zarocostas, 2010). Compounding the impact of the loss of staff from the ministry of health, 100 nursing students were killed in the collapse of one of three nursing schools in the country (Carlowe, 2010). This was particularly disconcerting because there was already a workforce shortage of nurses (Roye & Nikitas, 2010).

Field hospitals, mobile clinics, and other temporary emergency resources became available in surplus after the earthquake. Health professionals with intentions of servicing patients as well as with ambitious goals to build capacity among Haitians through education and training inundated the country (Carlowe, 2010). In some instances, there was more aid than capacity to receive the aid (Rhea, 2010). Many medical providers were eager to travel immediately to Haiti but found that they could not due to coordination barriers. Scarcity of essential resources such as food, clean water, proper sanitation, and electricity, further prevented the deployment of medical teams to Haiti. Organizations already on the ground could not afford to have more teams of people come and deplete what little resources remained available (Rhea, 2010).

The first field hospital was established by the University of Miami Global Institute/ Project Medishare (CDC, 2010). From this hospital, it was reported that during the first five months of care, patients were mostly young males and on average remained in the hospital for two weeks with earthquake-related injuries. In the initial phases of emergency care, patients

mostly sought treatment for fractures/dislocations, wound infections, head, face, and brain injuries, and for surgical amputation (CDC, 2010). Hospitals in areas unaffected by the quake became depots for injured survivors from affected areas (Rice, Gwertzman, Finley, & Morey, 2010). Pape, et al. (2010) report that clinics, that originally served special clinical populations or provided specific health services, converted into field hospitals to deliver emergency care.

Many injured survivors in Port-au-Prince immigrated out of the capital to rural areas to find emergency care (McIntyre, et. al., 2011). One NGO, whose history in Haiti and relationship with the Haitian government is well known internationally, became the central organizing group of medical services. *Partners in Health* (PIH), or Zanmi Lasante (ZL) in Haitian Kreyol, was co-founded over 20 years ago by Dr. Paul Farmer of Harvard University (Kidder, 2003). Dr. Farmer, appointed by former President William Clinton to be the UN Deputy Special Envoy to Haiti in 2010, has been working diligently with MSPP to deliver health care to Haitians in the most destitute rural areas of Haiti (PIH, 2011). Presently, PIH has eight health care facilities in Haiti, six of them in rural provinces around the central plateau (PIH, 2011). In less than one week after the earthquake, PIH rapidly organized international teams of medical providers to their sites. The organization worked collaboratively with MSPP to support a model of developing a sustainable health care infrastructure to eventually be operated by Haitians (Zarocostas, 2010), which is at the core of PIH's service model. To enhance services after the earthquake, PIH also relocated staff from the organization's rural hospital sites to a public hospital in Port-au-Prince (McIntyre et. al., 2011).

As a result of their pre-established role in Haiti, PIH served as a leading force in coordinating health services, while promoting cooperation between NGOs and MSPP (Ivers & Cullen, 2010). The call for partnership during the initial response phase was to advocate and

create the basis for a common goal in the reconstruction of Haiti's healthcare system. This was essential, as Aarabi, Smithers, & Muhkarjee (2010) report, given NGOs frequent practice of uncooperativeness and reluctance to partner with the government, preexisting NGOs, and native Haitian professionals. Although the lack of regard for collaboration with the Haitian government could be attributed to its infamous reputation for corruption and irresponsibility, Kidder (2010) contends that this reason alone is not an adequate excuse. Incoming NGOs disregard for the government, as well as for other experienced native professionals, frequently resulted in duplication of efforts and neglect of those in the most need. Aarabi, Smithers, & Muhkarjee (2010) indicate that many NGOs preferred to partner with private organizations, thus increasing the divide between the public and private sectors. In contrast, Kidder (2010) reports that PIH ensured that relief efforts at PIH sites and the public hospital in Port-au-Prince were led by Haitians, eliminating any "turf wars" between representatives from other groups at the hospitals. Hospital directors were pleased with this type of collaboration with NGOs (Kidder, 2010).

Despite the important exceptions like PIH, for many of the NGO-led efforts, security and coordination of services were reported to be problematic. Peleg, Kreiss, Ash, & Lipsky (2011) noted their difficulties in coordinating and taking full advantage of medical resources at field hospitals. Though they eventually created a referral system with other field hospitals, establishing a strong medical network to more productively accommodate patients, the authors advise future disaster medical responders to create this system prior to entering the field to begin relief efforts. Their advice was proven to be valuable by medical teams who created a system for delivering care before traveling to Haiti.

For example, a consortium of medical centers from six Chicago-based universities collaborated with NGOs already in Haiti, making use of preexisting relationships with these

groups to create an efficient network of care. The consortium deployed medical teams to Haiti weekly and maintained communication with deployed groups through conference calls three times per week (Babcock et al., 2010). McCunn et al. (2010) report similar success with a team of anesthesiologists from the University of Pennsylvania who collaborated with PIH in coordinating health care in Haiti from their base in Philadelphia. Auerbach, et al. (2010) also describe their experience in a joint civilian and military personnel operation in the initial medical response phase as ultimately successful. At first, offering the best care to patients at their site after the earthquake proved to be challenging given difficult weather conditions and a lack of security. As physicians and nurses from prestigious university medical centers in California and New York, Auerbach, et al. maintain that despite setbacks in communication, the teams worked collaboratively to form a secure, organized, and efficient medical care. It was also noted that keeping families of patients informed and in one place was given high priority. This was not the case for some sites, as injured children were reported to be displaced from their families while receiving medical treatment (Pape et al., 2010).

Religious groups, some of which had a strong presence in Haiti prior to the earthquake, also contributed significantly to the initial medical response (Zigmond, 2010). Many partnered with state hospitals in the US to raise funds and give care. Catholic Relief Services (CRS), which had plans to improve Haiti's health system through the construction of two universities, also shifted their priorities in an effort to respond medically to injured earthquake survivors. Compton (2011) maintains that CRS still hopes to be involved in rebuilding the health care system in the following areas: health services, health workforce, medical products and technologies, financing, information systems and leadership governance.

Providers' Experiences

Since January 2010, an array of articles from providers reflecting and commenting on their experience in Haiti after the quake has appeared, in addition to the articles describing the successes and failures of strategies implementing health care that were reviewed in the previous section. Many health care professionals, particularly nurses, felt compelled to share their stories with the academic community. Notably, many of the articles include pictures of patients, the physical devastation around the cities, and the impoverished conditions under which professionals worked. The authors of these articles were certain to recount their emotional experience as well as their physical states when responding to patients. They give detailed descriptions of the patients they served, often discussing patients' attitudes and expressions of gratitude or of concern during providers' brief interactions with them. The stories convey a desire to capture the interpersonal aspects of health care interactions.

For instance, in a thoughtful and emotional reflection on the ethical concerns of working in makeshift healthcare delivery facilities after the earthquake, Young (2010) describes the scene that many of those who provided relief faced on a daily basis, "The Line starts forming at about 5:30am…. We see 350 to 475 patients by 5:30pm" (p. 921). Young continues to capture the overwhelming needs of most patients and the inadequacy of available resources in this passage:

> Our resources include eager and skilled expatriate medical professionals, most necessary medications, and a little bit of equipment. But the needs are buildings and clinics and operating rooms, local physicians and nurses, electricity and houses and medicine for daily use, psychiatrists, food and water, crutches, and a job, and a place to mourn. The needs are endless, and only a small portion are medical (Young, 2010, p. 921).

Young discusses the constant negotiations that were made about patients' lives and their needs for care that many nurses also attested to in their reports on the experience of servicing hundreds of patients in community hospital triage areas (Ricciotti, 2010; Pierre-Pierre, 2010; Trossman,

2010). It was common for patients to die not because of injuries sustained during the earthquake but because of medical complications due to lack of basic needs like running water, sanitation, food, or electricity to properly care for themselves and their illnesses. The strong aftershocks that followed the original earthquake also worsened patients' injuries, as they would run out of hospital buildings in fear of the buildings' collapse (Miller, D., 2010).

Miller (2010) reflects on the many hats that had to be worn given the circumstances, some outside of the realm of her expertise. Flexibility and improvisation were the main tools of healthcare professionals (Riccotti, 2010), as they assumed multiple roles in attempt to satisfy the multitude of patient needs (Carlowe, 2010; Auerbach, et al., 2010). Nurses reported feeling emotionally and physically drained from the work, more than in any other medical rescue mission they had ever experienced (Trossman, 2010). Even those who were familiar with the cultural context, as members of the diaspora, felt unprepared for the devastation (Bayard, 2010). Apparently, media coverage of the earthquake in the US did not accurately depict what was witnessed upon providers' arrival in Haiti. Deckelbaum (2010) describes the scene:

> There were two to three patients on each bed, patients under beds and patients on the floor between beds. In the first 48 hours after the earthquake, more than 600 patients arrived at this 80-bed facility. Privacy was nonexistent. Bathroom facilities were out of the question for patients with incapacitating orthopedic injuries (Deckelbaum, 2010, p. E241).

Hospitals were filled beyond capacity in the days following the earthquake, resulting in less consideration for confidentiality in the effort to deliver urgent health care. Patients were given the most basic services and often sent to their tents because of limited space in clinics and hospitals. Patients who insisted on staying were denied (Deckelbaum, 2010).

Rosborough (2010) supports Deckelbaum's report in his commentary on the lack of observance to procedures that would ensure patient privacy. Discussing human rights in

international disaster contexts, Rosborough compares two field hospitals, the first hospital without trained staff in disaster response and the other with trained leadership in this area. There were no private latrines, no water for patients to wash their hands, no privacy in tents, no record keeping system for patients, and no protection of orphaned pediatric patients at the hospital with untrained staff.

It was also reported that untrained physicians were likely to describe the hospital setting in disparaging terms to their staff, calling the scene a “war zone” and giving permission for a lax attitude towards patient care. This was in deep contrast to the field hospital with a trained international disaster medical response team.

In contrast, the hospital with a trained team had water and restroom facilities and provided hygiene kits consisting of toothbrushes, soap, and other personal items to registered patients. Patients received tetanus and measles vaccinations and were fed three times per day. Children who arrived alone were also registered with UNICEF for their protection. The team maintained a proper record keeping system, a staff roster sorted by specialization, and daily team schedules, all assisting with the organized operation of the team. In addition, staff was housed away from the patient area. Patients reported feeling satisfied with the service and felt safe at the hospital. Although this site serviced a similar number of patients to the other site, they were more successful in their mission because of adequate preparation, making a clear argument for training in disaster medical response. However, Rosborough’s criticism of the unprepared sites mismanagement of patient records may have been unwarranted, as many sites reported difficulties in maintaining proper records not because of lack of preparation but simply due to the high demand for medical services (Trossman, 2010; McIntyre et. al., 2011; CDC, 2010).

Adherence to ethical codes of medical practice was also of concern among medical teams (Etienne, 2011). VanHoving, Wallis, Docrat, & DeVries (2010) report alarm about the blatant disregard for ethical codes by medical providers who appeared to be exemplifying the modern definition (Jobe, 2010) of “disaster tourism.” These providers were criticized for traveling to Haiti for media recognition and self-promotion, often bypassing governmental restrictions in fulfillment of their agendas. In addition, these providers were accused of building false hope in patients, and then quickly return to their countries of origin, leaving patients disappointed and discouraged by unfulfilled promises. Providers are implored to engage in volunteer disaster response with more than good intentions.

Language barriers also posed a hindrance to patients receiving an optimal level of care. Medical teams found that many patients did not speak French, in spite of it being an official language of Haiti. Although most hospital communications and patient documents were written in French (Rice, Gwertzman, Finley, & Morey, 2010). Haitian Kreyol translators were a necessity, equated to respecting Haitian hospital staff and obeying hospital policies.

The Patients

For many patients, the outpouring of medical support was an opportunity to receive care that they had not been able to afford prior to the earthquake. Patients were usually young, under the age of 20, reflecting the demographics of the general population, with half of the population under 20 years of age (Broach, McNamara, & Harrison, 2010). Bratten (2010) notes the hardworking and resilient attitudes of patients, describing them as “quiet, strong, gentle, and proud” (p. 14). Patients would come from afar for services, walking many miles and on uneven terrain, in order to receive usually inaccessible medical care. Patients often expected to leave with medicine and other medical supplies after a medical visit, which was speculated to be a

desire for tangible proof of their visit, (Broach, McNamara, & Harrison, 2010). However, it is possible that patients received satisfaction in knowing that they sought care and received resources in return, creating a sense of empowerment and self- agency.

In some cases, patients grew attached to providers, "There, a three-year-old boy captured her attention- and heart- by climbing up on her and resting his head against her" (Trossman, 2010, p. 8). Patients were especially proud of Haitian practitioners who returned to help after the quake, although at times teasing the heavily accented Kreyol of the diaspora and second-generation Haitian- Americans (Bayard, 2010; Etienne, 2011). Despite reporting frequent feelings of hopelessness, nurses also reported on the encouragement that they felt from patients' optimism and great expressions of gratitude (Ricciotti, 2010). Other accounts of patients' demeanor describe patients as stoic or unmoved by the chaos and horror of the medical settings (Deckelbaum, 2010). Yet, patients were mostly depicted as prideful, positive, resilient, and helpful (Trossman, 2010; Bayard, 2010; Carlowe, 2010).

Problems with Repairing the Health System

The recent cholera epidemic further delayed the recovery of the health system. In October 2010, a cholera outbreak allegedly caused by Nepalese peacekeepers, began to ravage the Artibonite department of the country (CDC, 2011). Since this time, the number of cholera cases has increased from under 100 cases to almost 100,000 cases in the past year across the country, with the risk of death within two hours of experiencing symptoms (CDC, 2011). The accelerated pace of the disease can be attributed to the poor sanitary conditions and minimal access to clean water in Haiti. Great attention and resources have been devoted to preventing and containing the spread of cholera among the population. The Center for Disease Control has advocated for better and permanent systems for purifying water, obtaining clean water,

improving education for the population on hygiene and sanitation, and creating a sanitation system in cholera treatments centers to maintain a clean treatment environment (CDC, 2011).

In addition to the cholera epidemic, the entry of foreign doctors in Haiti after the earthquake has also affected the reform of the health care system. Foreign practitioners delivering health care for free created competition for native doctors whose private practices suffered greatly without paying patients. But not all Haitian health professionals have been hindered by the presence of foreign providers. Some have benefited from NGOs like *Doctors without Borders*, who were among the leading organizations coordinating the emergency medical response after the earthquake and hired about 1000 Haitian doctors and nurses for their facilities (Adams, 2010). Other organizations like PIH and International Medical Corps (IMC) ultimately discontinued the deployment of foreign volunteer teams to Haiti to assist in building capacity and sustaining resources among Haitian professionals.

Despite these efforts, German professionals from *Doctors without Borders* have expressed concern about the shortage of Haitian professionals in Haiti once foreign professionals leave and the country becomes more stabilized (Arie, 2010). Government offices remain understaffed and with minimal incentives to stay, Haitian doctors may continue the pattern of leaving Haiti to work in other countries. Prior to the earthquake, Haitian doctors habitually left the country to work in countries with better employment benefits such as France, Canada, Cuba, and Africa. For those practitioners who remain in Haiti, they are hopeful that they will eventually receive reimbursements from the government for wages lost during the emergency medical response after the earthquake (Adams, 2010).

While some groups work to increase the pool of skilled and affordable Haitian health professionals, DeGenarro, Jr., DeGenarro, Sr., & Ginzburg (2011) argue that foreign

professionals are needed in the interim to accomplish long-term goals of establishing a better functioning healthcare system. DeGennaro, Jr. (2011) also maintains that foreign health care professionals should remain in Haiti to offset the shortage of Haitian health professionals, although he emphasizes that employment for native Haitians should be secured before employing foreign health professionals. Ivers (2011) advocates that foreign organizations look to the precedent set by successful NGOs, like PIH, in developing health systems that both train and employ Haitian professionals, ultimately creating a sustainable health care system without the need for foreign assistance.

The 2004 Indian Ocean Tsunami has been compared to Haiti's earthquake in regard to the prospect of building a better Haitian society through the influx of foreign groups. Morris (2010) remarks that Haiti, like Indonesia had, has the opportunity to reconstruct a more organized, secure, and trusting society through relief and reconstruction efforts. However, Morris warns that Haiti will not be like Indonesia without foreign help and improvement in the areas that already posed problematic to the functioning of the society prior to the earthquake, particularly the existing social hierarchy and the control of the Haitian elite. Although they represent a small percentage of the population, they maintain a significant amount of power in the government.

Lastly, because of the foreign medical response, and the need to send patients to other countries to receive better services, patients established connections with networks of people once completely unavailable to them (Morris, 2010). As a result, this may have also disrupted the health care system as well as the family lives of these patients, as some patients found better opportunities in host countries and did not return.

Quality of Health Services and the Provider-patient Relationship

Absent from the literature on the health system in Haiti prior to and after the earthquake is information on the quality of services that were provided and are presently being provided by the amalgam of health professionals in the health care system from the patient's perspective. From studies conducted in the United States, it is known that patients' perception of health care quality is greatly shaped by the quality of the interpersonal relationships established with providers (Sofaer & Firminger, 2005). Patients' expectations for care are based on the level in which a provider can develop a trusting and empathic relationship (Irvine, 2007; Lings, et al., 2003).

Four predominant models of patient interaction are discussed in the medical field: the paternalistic model, the informative model, the interpretive model, and the deliberative model (Emmanuel & Emmanuel, 1992). Among the four models, the paternalistic model is more traditional and believed to be more commonly practiced in developing nations, particularly in the Caribbean (Xanthos, 2007). The paternalistic model promotes a type of physician-patient relationship in which the patient's treatment and diagnosis is heavily based on the provider's judgment and expertise, without much regard for the patient's preferences.

In the vast literature on physician-patient relationships in the US, a shift in the preferred model of interaction among providers and patients has been identified. Perhaps as a result of an increasingly multi-cultural American society and ample studies revealing the disadvantages of disregarding patient health values and preferences (Flocke, Miller, & Crabtree, 2002), "patient-centered care" is presently at the focus of medical education and practice (Richard, 2008; Kondro, 2010; Ho & Byung, 2007). The patient-centered model differs from the other models that purport a single-sided level of interaction in that it promotes engagement of the patient in the

medical process. The paternalistic model has also been noted to pose the threat of medical malpractice because of the propensity for physician fatigue and an attitude of indifference among those providers who ascribe to this model of practice (Kondro, 2010). Globally, both researchers and practitioners have been arguing for an international standard of patient-focused care, listing greater satisfaction with care and adherence to treatment as a possible outcome among patients (Xanthos, 2007; Stewart, 2001;Unger, Gjilbert, & Fisher, 2003; Abdel-Tawab & Roter, 2002).

In addition, the patient-focused model allows the patient narrative to be told and utilized in satisfying medical needs. Physicians have been criticized for depersonalizing the diagnostic and treatment process, neglecting traditional methods of attending to the patient's story (Borkan, Reis, Steinmetz, & Medalie, 1999; Irvine, 2007). In Haiti, the patient's narrative has not been sufficiently sought and explored, empirically or anecdotally.

Models of Illness and Traditional Healing in Haiti

Multiple explanatory models of health and illness in Haiti have been documented (Miller, 2000; Farmer,1990; Maternowska, 2006; Nicolas & Rendon, 2010; Haitian Red Cross, 2010). Generally, illness representations in Haiti derive from strongly held cultural, religious, and sociopolitical beliefs, depending on an individual's or community's ethnicity, religious background, socioeconomic status, or educational level (WHO, 2010; Miller, 2000). The four common explanations for illness include illnesses of natural origin (God, psychological stress or shock, imbalance of physical temperature, etc.) malevolently conspired and supernaturally transmitted illnesses (sorcery, “zombie illnesses,” “evil spirit illnesses,” etc.) and “public illnesses” (cholera, HIV/AIDS, TB, etc.) that are often attributed to nationally-impactful and upsetting social or political events (WHO, 2010; Maternowska, 2006; Farmer, 1990; Vonarx, 2007).

In a report of perceptions of cholera completed by the Haitian Red Cross in Decemeber 2010, members of the studied community offered explanations for cholera since the earthquake that were aligned with the models described above. However, there appeared to be an emphasis on the allegations against the UN peacekeepers, with many study participants feeling that the disease was purposely brought into Haiti, similar to feelings about HIV/AIDS during its beginnings stages in the 1980s (Farmer, 1990).

Nicolas & Rendon (2010) present four stages of illness commonly endorsed by Haitians, ranging from mild to severe symptons: 1) I do not feel well, 2) I am sick, 3) I am very sick, and 4) I am dying. Healing methods for illness depend on the explanatory model one chooses. Healers and healing methods that would be sought or practiced range widely and many choose to use multiple sources of healing (Miller, 2000). Whether a patient decides to seek an herbalist, Vodou priest, or physician often depends on his/her explanation for the onset of the illness.

Study Summary

The purpose of this qualitative study was to explore with a moderate-sized sample of patients and health care professionals in the US and in Haiti their perceptions of receiving or giving care in Haiti since the earthquake of 2010. It was hoped that understanding the perceptions that patients and practitioners held of each other, as well as their beliefs about illness and traditional medicine, would elucidate the types of patient-provider relationships existing in Haiti, especially since the earthquake that brought into the country a highly diverse and large group of health care providers.

This study was guided by the data-gathering and data-analyzing processes of *Grounded Theory* and my direct observations of provider-patient relationships in Haiti after the earthquake. Semi-structured interviews, both group and individual, were conducted with a total of 46

participants. Demographic data were analyzed with information collected from all 46 participants. However, one participant's individual interview was excluded from the qualitative data analysis because of problems with the audio file. The study was conducted in two phases, with the first phase being in a northeastern state of the United States, and the second phase being in the capital area and a southern province of Haiti. For the second phase, data were collected at three medical sites.

Participants were American or Haitian health care providers and Haitian patients. American providers had either volunteered in Haiti before or were currently volunteering in Haiti at the time of the interview. Haitian providers were working at the medical sites at which the interview was conducted. Patients were receiving care on the day that their interviews were being held.

During private, audio-taped interviews, participants from both phases were asked to discuss their beliefs, perceptions, and experiences in health services in Haiti since the earthquake. The study was based on the following primary research questions:

1. What are Haitian, as well as foreign health care providers,' perceptions of Haitian patients?
2. What are Haitian patients' perceptions of foreign health care providers, compared to native Haitian health care providers?
3. How do beliefs about the causes of illness, models of health care interaction, and traditional healing practices affect provider-patient relationships?
4. What other factors within the provider-patient relationship affect patients and providers' perceptions of health services?

Findings from the study largely answer these four questions, mainly providers and patients' perceptions of each other, the relationship between participants' beliefs about illness and healing methods and the provider-patient relationship, as well as other factors that impact this same relationship. Data on participants' perceptions of health services since the earthquake are also presented.

Chapter Three: Methodology

Introduction

The purpose of this qualitative study was to explore the experiences, beliefs, and perceptions of relationships between healthcare providers and patients in Haiti. In addition, participants' beliefs about illness and attitudes about traditional healing methods were explored. The data gained from this exploration were sought with the intention of contributing to the information on services delivered to patients receiving care in a vulnerable health environment.

This chapter describes the study's research methodology and includes discussions around the following areas: (a) the rationale for a qualitative research design, (b) an overview of the research design, (c) the information needed to conduct the study, (d) the research sample, (e) the research setting, (f) procedures, (g) data analysis and synthesis, and (h) and the ethical considerations in collecting data.

Rationale for Qualitative Research Design

This study is guided by the research principles and methods of qualitative research, particularly *Grounded Theory*, a qualitative research method that utilizes inductive techniques of data collection and analysis for the construction of a theory derived directly from the data source (Charmaz, 2006; Creswell, 2007). Although the approach is credited to two sociologists, Barney G. Glaser and Anselm L. Strauss (Bryant & Charmaz, 2010), different approaches have derived from the original conception of the approach (Creswell, 2005). This study follows the methods of Kathy Charmaz (2006), which emphasizes the deliberate as well as inadvertent contributions of the researcher to the study process (Green, Creswell, Shope, & Clark, 2010). Qualitative methodology in general allows for the investigation of phenomena within the field or in its natural setting (Patton, 2002). For this study, the perceptions of providers and patients were

explored at the medical sites at which the interactions between providers and patients actually occurred. In some instances, I had the opportunity to make direct observations and note of the interaction between providers and patients during medical consultations.

Qualitative inquiry also allows for the use of multiple methods of data collection, such as observation, survey, case study, and interview. Interviewing is noted as a standard and "powerful" method in qualitative research (p. 645, Fontana & Frey, 2003), and can include group and individual interviews. Focus groups, also referred to as group interviews, allow gathering information on a particular topic from multiple individuals at once, which is cost-effective and beneficial to participants for a more accurate recall of events and experiences. Data is obtained from group participants through exploratory interviewing (Fontana & Frey, 2003). In addition, qualitative methodology, principally the approach of grounded theory, allows for an emergent study design, which gives the researcher flexibility in selecting data collection tools that are appropriate and aligned with the information being collected as it is gathered by the researcher (Creswell, 2007; Charmaz, 2006). Given the absence of studies on perceptions of health services in Haiti, this approach was found to be best suited for what appears to be a novel investigation into this context.

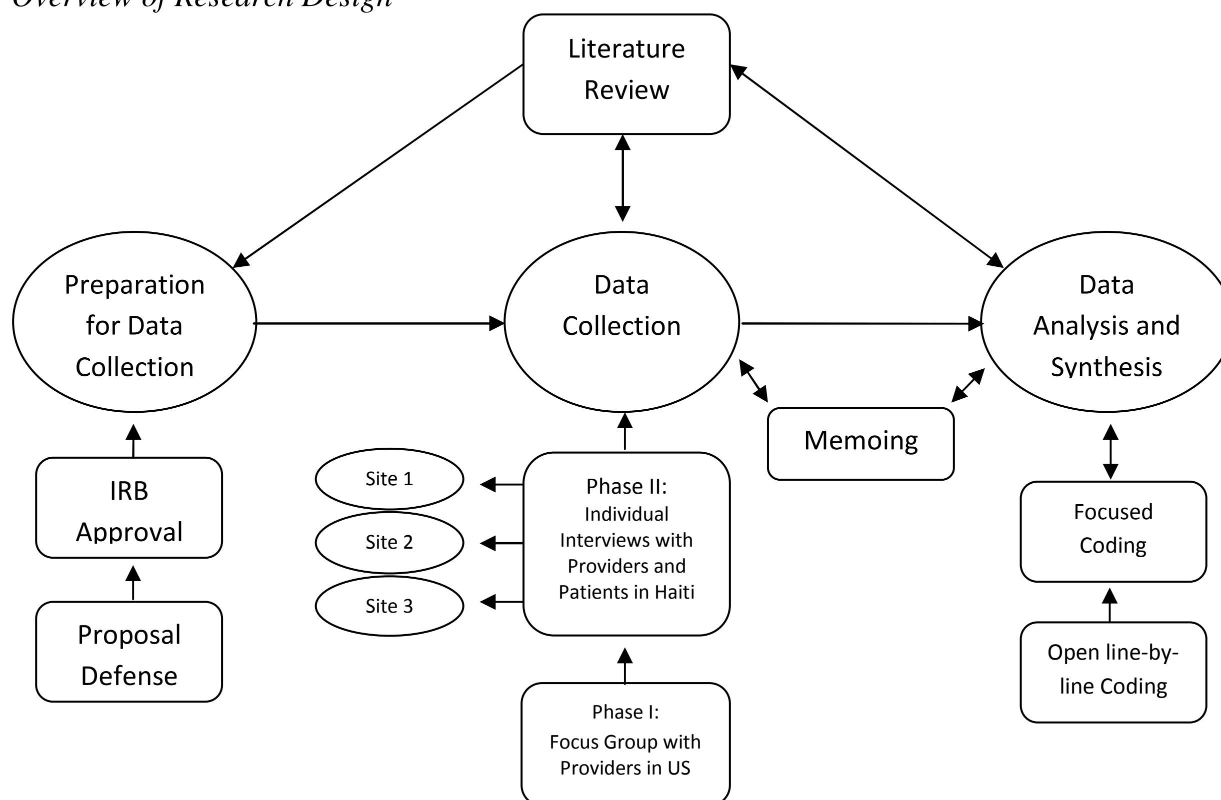
In addition to requiring that data analysis occur along with data collection, the traditional practice of grounded theory holds that hypotheses should not be produced prior to data collection (Charmaz, 2006). As such, hypotheses for the research questions were not generated before beginning the study. Once data were aggregated and analyzed for themes, meaning was directly gleaned from the participants' description of their experience, instead of drawing from the existing literature to interpret and synthesize the data.

Overview of the Research Design

For this study, two qualitative methods were utilized to collect data. For the first phase of the study, a focus-group in the US with health care providers who volunteered in Haiti soon after the earthquake was conducted. Findings from this group interview were used to assist in the development of the interview questions for phase II of the study. In the second phase, individual in-depth semi-structured interviews with health care providers and patients at three different medical sites in Haiti were conducted.

In keeping with the approach of grounded theory, relevant literature at all stages of the research process were searched for and reviewed, following the themes emerging from the data as it were being collected (Charmaz, 2006).

Figure 1
Overview of Research Design



For the analysis, two coding methods, an initial line-by-line coding analysis and a focused coding analysis, were used (Charmaz, 2006). Memoing, a technique used for interpreting data findings (Bryant & Charmaz, 2010), was conducted between the data collection and data analysis phases.

Information Needed to Conduct Study

Utilizing the qualitative methods described in the previous subsection, I sought to gather (a) perceptual, (b) contextual, and (c) demographic information to answer the four research questions generated prior to data collection. Within these three categories, the information sought included:

- Foreign and Haitian-native providers' overall perceptions of Haitian patients, as well as their perception of patients' needs within the provider-patient relationship.
- Haitian patients' overall perceptions of foreign health care providers compared to Haitian-native providers in addressing their health care needs within the provider-patient relationship.
- Providers and patients' beliefs and attitudes about illness and traditional healing methods and how it affects the provider-patient relationship.
- Participants' proximity to the earthquake in 2010 and their perception of its impact on the health care system.
- The impact of the earthquake on the data collection sites and changes to the delivery of health services at the sites since the earthquake.
- Participants' characteristics, including age, sex, educational level, subjective socio-economic status, subjective racial and ethnic identifications, language fluency, and residence. Patients were asked additional questions about means of paying for services

and their reasons for visiting the site on the day of the interview. Foreign providers were asked additional questions about previous experience providing post-disaster services and organizational affiliations.

The Research Setting

Phase I. The focus group interview for this phase was held in the conference room of a participant's work office in South Windsor, Connecticut.

Phase II. Site One: Port-au-Prince-area hospital. Site One is an 80-bed private faith-based hospital in a mountainous area about 20 minutes north of Port-au-Prince. The hospital boasts of having an Haitian-only staff who provide very low-cost services in pediatric, maternity, and out-patient care to over 18,000 patients per year. However, it should be noted that in spite of the low cost of services (by US standards) patients in this study often discussed the cost of care being a barrier to receiving services and some patients explained that they rely on funding granted to specific programs, like the HIV/AIDS care program at the hospital, to receive services.

There is also a pharmacy on site and many educational and training programs for the surrounding community are offered. For example, on the very first morning on site, I was greeted by a group of over 20 male and female elderly midwives in the office of the HIV/AIDS clinic director. The director later informed me that the group had just completed a monthly refresher training course in maternal health and midwifery. The group came back to express their deep gratitude to the director for the training.

For this study, participants were interviewed from the HIV/AIDS and primary care out-patient clinic of the hospital. The clinic appears standard with a patient waiting area and a receptionists' office at the entry and seven private consultation rooms in a back corridor. Patients

view educational programs on various health topics on a large television in the waiting area. The programs feature Haitian actors and health educators and are in Kreyol. Also in the waiting area are posters from the ministry of health on safe sex and cholera, with detailed explanations on how to protect oneself from both.

Individual interviews with providers and patients were conducted in the consultation rooms, as they became available. On one occasion, I was asked by a physician to sit in with him during a consultation. This physician would be interviewed later in the week. Findings from the individual interview and observations from the consultation are discussed in the next chapter. Overall, interviews were conducted in private, quiet, and comfortable spaces within the clinic. Interviews were completed over the course of five days in a two-week period.

Site Two: Port-au-Prince-area NGO clinic. The clinic was located on a waterfront pier in a highly neglected, and once very violent, community also north-west of Port-au-Prince. The clinic comprised of three large domed-shaped plastic tents and two small cemented one-story block-shaped buildings. Physicians and nurses providing services at the site were from two US-based non-profit organizations that organize medical mission trips to Haiti three times per year. Most of the 10 health professionals who had volunteered for this trip had worked in Haiti before in similar capacities. The clinic was also staffed by members of the local community who served informally as translators and medical and administrative assistants. The site was crowded daily, with over 600 people in line for services from the Friday to Sunday that the visiting professionals were there.

For the study, I met the providers at their hotel at 7:00 am during the three days and rode with them to the site, about 15 minutes away from the hotel without traffic delays. This arrangement was made because of the difficulty in securing direct transportation to the site. This

was due to the community’s notoriety as a troubled zone, which I now believe has been misrepresented. The providers began their mornings with breakfast and conversation about the day ahead. Notes from the breakfasts with the providers, as well as notes from the discussions during the ride to the clinic are discussed in the next chapter.

Site Three: Les Cayes area hospital. Site three is a 146-bed hospital that services on average 36,000 patients per year. Staffed by Haitian physicians, nurses, and other health professional staff, the hospital is the main health care facility in the area. Many participants of this study discussed the hospitals role after the quake in providing services for an overwhelming amount of patients who traveled from the main disaster areas of Port-au-Prince and Jacmel to receive care.

For this study, participants were interviewed from the Maternity, Surgery, and Primary Care units of the hospital. Interviews were conducted in available office spaces, the intern residence hall, and vacant corners of a unit. Every effort was made to find the most private and quiet spaces, yet in some instances privacy was more achievable than quietness. In addition, some providers preferred to have other providers in the office during their interviews. It should be noted here that some participants appeared wary of me and this study. Some providers and patients requested additional explanations and in some cases, personal background information about me, before agreeing to participate. One nurse, who had agreed to participate when first approached, refused after the consenting information was reviewed. In all instances, the interview did not begin until participants felt they had received sufficient explanation about the study and were comfortable to begin. As mentioned above, some participants preferred to have colleagues or accompanying persons with them during the interview, even after the purpose of

the study was explained. At this site, interviews were completed over the course of eight days in a period of two weeks.

Procedures

Phase I: Focus group with providers in cthe United States. Participants were recruited through a detailed letter sent through the email listservs of the two Haitian professional organizations based in Connecticut. It was my intent to select participants representing the range of professionally, racially, and ethnically diverse healthcare providers that were sent from the organizations to Haiti up to one year after the earthquake. However, after a week of soliciting participants, only six health professionals responded indicating their interest in participating in the study. I began scheduling the date of the focus group with the six responders, while inviting more participation from other members on the organizations' listervs for another week. There were no additional responders and the interview was scheduled for the evening of Thursday, June 6th, 2012.

Although 6 participants confirmed their attendance in the days before the focus group, only 2 were present at the time the group convened. A third health professional, who was present for another Haiti-related meeting following the focus group, agreed to participate. However, within 20 minutes of the interview, the participant declined to participate further, explaining that his mission trips to Haiti after the earthquake were not to provide health services; he did not feel that he could contribute to the discussion. Thus, the interview was conducted with two participants. Before beginning the interview, participants were asked to review and sign a written informed consent. In one-hour 20-minute semi-structured interview, participants discussed their experience and perceptions of their volunteer work in Haiti after the earthquake. More specifically, participants were engaged through open-ended questions about their experience

providing health services and their perceptions of the quality of interpersonal relationships developed with patients during their time in Haiti. Participants were also asked to reflect on what they believe to be vital interview questions for providers as well as patients in the second phase of data collection, based on their experiences delivering care in Haiti.

One attendee of a prior meeting, and friend of a research participant, asked to stay and observe the focus group meeting. With the permission of participants and after signing a consent form, the attendee was allowed to stay for the interview.

After the group interview, participants were asked to complete a brief self-report demographic questionnaire including standard survey items about age, sex, racial and ethnic identifications, education, language, and profession. Questions regarding the providers' previous professional international experience were also asked. The interview was audio-taped while I took notes.

Phase II: Individual interviews with patients and providers in Haiti. For phase II, participants were recruited with the help of an assigned staff person, by the directors of the first and third sites. Potential participants were approached by the staff person and then referred to me for more information about the study. Once interest in participating was expressed, I obtained informed consent from the participant and began the interview.

After each interview, patients received a small unidentifiable grocery bag filled with rice and beans (valuing approximately $10) for their time. For providers' participation, a donation in the amount of $100 was given to the directors of each site. Compensation for participants was determined from many discussions with researchers in the fields of psychology, anthropology, public health, and nursing as well as other health professionals not participating in the study and the directors or leaders of the study sites, with the exception of one director who was interviewed

for this study. The compensation was deemed appropriate and non-coercive for the participants' time and information.

Interviews varied in length, the shortest being seven minutes and the longest being 56 minutes, with an average interview length of time being 25 minutes.

Interview Schedules of Questions and Demographic Questionnaires

Interview schedule development. The initial development of questions for the focus group and individual interviews were based on a preliminary review of the literature on the post-earthquake response and my experience participating in a medical mission trip to Haiti after the earthquake. I generated several questions, which were then reviewed and revised by the dissertation committee prior to data collection and further revised after phase I of the study. Findings from phase I, particularly participants' responses to the final group question were used in the development of the interview protocol for phase II of the study. However, the participants' responses to this question confirmed the direction of the interview schedule of questions already established. In other words, there was agreement among the participants of phase I on the information needed to be collected in the second phase of the study, especially from the patients. Once in Haiti, the questions were further revised as data were collected and certain questions emerged as more salient or for needed revisions in translation. The final drafts of the questions are presented in *Appendix B*.

Translation for Phase II. For phase II, interviews were offered in either English or Haitian Kreyol, depending on the participants' preference. Interviews were not offered in French, as I am not fluent. Upon finalization of phase II informed consent forms, recruitment scripts, interview schedules of questions, and demographic questionnaires in English, I translated all materials into Haitian Kreyol as a native-English and Haitian-Kreyol (as a second language)

speaker. For the purposes of cultural adaptivity and linguistic accuracy, several native Haitian-Kreyol and English (as a second language) speakers were receruited and selected to review some of the materials and provide feedback on the accuracy of the translations. The reviewers were of various professional and educational backgrounds and selected through multiple personal and professional networks. Reviewers were asked to examine the English and Kreyol-translated texts, as well as the back translations into English, and to provide feedback on a form (see A*ppendix A*). I then applied the feedback in revising the texts.

All qualitative data were transcribed verbatim in the language in which the interview was conducted. Plainly, interviews conducted in English were transcribed in English and interviews conducted in Kreyol were transcribed in Kreyol. To be sensitive to cultural concepts and linguistics, it was agreed that this was the best approach. Only the Kreyol-interview quotes presented in the next chapter have been translated into English, for the dissertation committee members and other English-speaking readers. The original Kreyol texts with the English translations can be found in *Appendix F*, in order of appearance in the chapter.

Subjective socioeconomic status and racial identification. In a thorough disaggregation of the construct of socioeconomic status (SES), Adler (2009) argues that measures of socioeconomic status in research are typically insufficient in accounting for the various and multiple economic resources that one may have. She indicates that asking about one's employment status, educational attainment, and salary is not enough to understand how one provides for oneself. Maintaining that understanding the components of SES is critical to understanding health disparities, her research on subjective status goes on to explain how "…self-perceptions may play an important role in health and the creation of health disparities" (p.667, Adler, 2009). She agrees that there is a correlation between socioeconomic status and

health and asserts that the mediators of this relationship can be psychosocial. In her research, Adler asked participants to report on their perception of their social status and later developed a scale for measuring social status that relied less on pre-existing classifications.

Drawing from Adler's work, on the demographic questionnaire for this study, participants were asked to report on their socioeconomic status and racial/ethnic identifications subjectively. In Haiti, these particular constructs are not so clearly defined or classified among Haitians. To account for this, I assessed for the participants' perceptions of their socioeconomic classifications and racial groupings. Of note, patients appeared much less comfortable with these questions than providers. Some patients inquired about my chosen identifications before providing their own answers. In regards to socioeconomic status, a couple participants offered their own descriptions of classifications beginning with *pov*, the Kreyol word for "poor," to *gran neg*, a colloquial term with a gendered connotation (masculine) for an affluent person.

Ethical Considerations

Protection of Participants. In keeping with the rules and regulations of the City College of New York's Institutional Review Board (IRB), I sought to protect the confidentiality and rights of participation of all participants. To minimize potential risks, the participants' names were not used on the data collected. Participants were immediately assigned an identification number upon agreement to participate in the study. Any identifying information inadvertly obtained during the auido-taped interview was removed from the transcripts. All data were maintained electronically and were password protected on my computer and external hardware device only accessible to me. Group interview participants were reminded that all information shared in the group session is confidential and cannot be discussed with nonparticipants after the interview. Hard copies of transcriptions and printed surveys/questionnaires organized by the

identification codes that each participant received were stored in a locked file cabinet. The flash drive used for electronically stored data was also kept in the locked cabinet when not in use.

For phase I, informed consent was provided in written form. For phase II, participants provided oral consent after I reviewed the purpose, procedures, risks, benefits, and confidentiality of the study. Given the low literacy rates reported in Haiti, oral consents were better suited for this phase of the data collection. To reduce bias and potential embarassment in attempting to determine literate participants, all participants were asked to provide audio-taped oral consent. However, written informed consent forms in English and Kreyol were made available for participants. Some participants chose to review the forms while I introduced the study. All participants were given written contact information for the study advisor, the univerity IRB, and me, in English and in Kreyol.

Concerns with Site Two. Unfortunately, very few participants were recruited from the clinic, as I ultimately decided that the environment was not conducive to data collection. Private interviews were difficult to conduct on site, both with patients and with providers, as securing a closed space where participants would not be observed by other patients standing in line to be serviced was not possible. Thus, three interviews were conducted on site, with one patient and two providers, and another interview was conducted in a private space in the lobby of a provider's hotel.

Compensating patients presented as another barrier in collecting data at this site. Prior to the arrival of the team members from the organization that granted permission for the study to be completed at the site, the director of the other organization informed me that he did not want patients to be compensated individually. He was concerned about the negative attention and disorganization that this would cause at the site. It was negotiated that I would instead give the

items to the director to distribute in a manner that was safer for all involved. However, when on site, this idea was abandoned and the director selected two support staff members to receive the food provisions. This misunderstanding, coupled with the privacy concerns, led me to make the decision not to interview participants, particularly the patients at the site. Instead, I served as an interpreter for a pediatrician and recorded notes from her direct observations of care delivery over the course of the three days on site.

Data Analysis and Synthesis

Storing and organizing data. Qualitative and quantitative data were stored, organized, and analyzed using multiple computer software programs, including *NVivo*, the *Statistical Package for Social Sciences* (SPSS), *Microsoft Excel*, and *Microsoft Word*. Demographic data were stored and organized in Excel, then analyzed in SPSS. Transcripts were uploaded into Nvivo for coding analyses using grounded theory coding methodology. In grounded theory, raw data are segmented into "thought units" (phrases that express one thought) through a process referred to as line-by-line coding (Charmaz, 2006). For this study, 33% of transcripts were coded using this method of initial analysis, which is noted to increase the credibility of findings and reduce bias (Charmaz, 2006). Following this process, I began focused-coding for the remaining transcripts. Focused codes, or first-order codes, are generated from or assigned to the units found in the initial coding process (Creswell, 2007). After the focused codes were generated, codes were further sorted, merged, and removed, creating a revised list of codes that were applied to subsequent interview protocols. The first-order codes are then assembled into higher order theoretical codes, or themes that continue to emerge as data is collected (Charmaz, 2006).

However, given the limitations of this dissertation study in design and time designated for data collection, all interviews were conducted during one two-month period and then analyzed

within a seven-month period following data collection. To this point, findings from this study should be reviewed as descriptions of emerging themes from these study data. There was no attempt to construct a theory from these data. Charmaz (2006) notes the importance in making this distinction.

Reliability. Inter-rater reliability was established by a seasoned colleague and me. Ten percent (n=4) of the interviews were coded, then reviewed by the co-rater until agreement was reached for at least 90% of the initial codes.

Memoing and Journaling. Memoing is a technique of grounded theory that assists with the analysis and synthesis of data (Bryant & Charmaz, 2010). Memoing allows for an open and flexible synthesis of findings as ideas surface throughout the data collection and analysis phases of the study process. For this study, detailed notes of ideas were kept in a notebook, while collecting data in the field, and in *Nvivo* when conducting the analysis of the data. In addition, a detailed electronic journal of thoughts and feelings about the study was kept on my computer throughout the entire study process. Notes from the memoing and journaling are weaved into the present and subsequent chapters.

The Research Sample

Doctors, nurses, psychiatrists, and prosthetists who volunteered through two professional Haitian organizations to provide medical services in Haiti after the quake were invited to participate in the first phase of the research study. Approximately one month after the earthquake, these organizations collaborated on efforts to organize and send volunteer teams to Haiti. The organizations raised funds and collected material donations in their local communities and partnered with three community hospitals in the Port-au-Prince area of Haiti to deliver health services. The first team to be sent comprised of 15 racially and ethnically diverse health

professionals and translators, some of whom had previous experience responding medically to similar disasters in Pakistan and Grenada. Many more teams were sent to Haiti through these organizations after this first deployment in March 2010. For this study, all volunteers were invited to participate. Ultimately, only two volunteers participated in the focus group.

For phase II, interviews were conducted with physicians, nurses, and patients from medical sites in the regional areas of Port-au-Prince and Les Cayes, Haiti. Twenty-two participants, eight Haitian-native providers and 14 patients, were recruited from a Port-au-Prince-area private hospital. From a Port-au-Prince-area US-based non-profit clinic, only three providers and one patient were interviewed due to ethical concerns discussed in the ethical considerations section of this chapter. From the third site, a public hospital in the area of Les Cayes, 19 participants, 10 patients and 9 providers specifically, were recruited. Thirty-nine of the 44 interviews conducted in Haiti were conducted in Haitian Kreyol. Out of the four interviews conducted in English, three were completed with American health care providers and one with a Haitian doctor.

Patients represented half (50%) of the study participants. Forty-eight percent of the patients were between the ages of 30 and 45. Providers from phase II, however, were on average younger than the patients, with 52% of the providers between the ages of 26 and 33. Participants were predominately female, representing 71% of providers and 70% of patients. Fifty-six percent of patients lived between an hour to three hours away from the medical site.

Although 44 individual interviews were completed in Haiti, one interview was excluded from the transcript analysis due to problems with the audio-recording that was discovered upon

transcription. *Table 1* below displays the total count of participants[3] by their phase of participation and location of the interview.

Table 1. *Study participants by phase and site.*

	Phase I ***N=2***	***Phase II*** ***N=44***		
	Focus Group *n=2*	**Site One** *n=20*	**Site Two** *n=4*	**Site Three** *n=20*
Providers *n= 23*	*Kadir* *John*	*Caroline* *Geraldine* *Olivier* *Nickson* *Delner* *Regine* *Benny* *Merline*	*Barbara* *Paula* *Suzanne*	*Fritz* *Melissa* *Marjorie* *Nicole* *Angela* *Babette* *Annaise* *Luc* *Sophia* *Luriene*[4]
Patients *n=23*		*Marie-Solange* *Aurelie* *Sergina* *Pierre-Jacques* *Nicolas* *Fredeline* *Rachel* *Jean-Paul* *Chantale* *Nerlande* *Lucien* *Nadege*	*Marie-Jocelyn*	*Jean-Phillipe* *Francoise* *Hugh* *Rose* *Betty* *Nadia* *Martine* *Ronald* *Louise* *Helene*

Summary

In this chapter, an overview of the study methodology was provided. The rationale for a qualitative study design that loosely followed the tradition of Grounded Theory was presented. The study was conducted in two phases, the first phase being in the US and the second at three

[3] Participants were assigned pseudonyms to protect their identity.

[4] This participant's interview was excluded from the qualitative analysis.

medical sites in Haiti. A focus group interview with two health care providers for the first phase of the study was conducted and in the second phase, 44 individual interviews were conducted with health professionals and patients. The next chapter describes the findings from the demographic and qualitative data analyses.

Chapter Four: Results

This chapter presents the key findings obtained from a group interview and 43 in-depth individual interviews with health professionals and patients in the United States and in Haiti. As mentioned in the previous chapter, one interview was excluded from the transcript analysis. However, the demographic information for this interviewee was still included in the demographic analysis, thus the total of participants for the demographic analysis is 46 (the sum of two focus group participants plus 44 original individual interviewees). Observations that were documented through field notes are woven into the findings as they relate to the themes presented.

Demographic Data

One hundred percent of patients reported fluency in Kreyol, with 78% indicating a proficient level of fluency.[5] Twenty-six percent of patients indicated that they could speak Kreyol but not read or write in the language. Almost 35% of patients reported speaking up to two languages including Kreyol and French, with only four reporting beginning to proficient levels of fluency in English and Spanish. Compared to patients, providers reported beginning (n= 7) to proficient (81%) levels of fluency in up to four languages including French, Kreyol, English, and Spanish. Only two providers did not speak any other language.

Fifty-seven percent of providers were physicians, with only a few (n= 7) indicating their specialties, including pediatrics, gynecology, community health, dermatology, maternal health, and pulmonary services. Thirty-eight percent of participants had been practicing for five years or

[5] It should be noted that the questionnaire was revised before collecting at the third site to ask about reading and writing proficiency in Kreyol. This revision was made to account for the socio-political issues around the Kreyol language. It is known that while most Haitians speak Kreyol, the orthography of the language is relatively new and many Haitians, of varying literacy levels in any language, are not yet fluent in the reading and writing of Kreyol (Faraclas, Spears, Barrows, & Pineiro, 2010).

less. Fifty-two percent of providers perceived their socio-economic statuses to be in a middle-income range.

In regard to patients, 78% were employed in a wide variety of work. Twenty-six percent of patients reported no formal education or training, with 61% having at least attained a secondary education or higher. Three of the patients also worked at the healthcare facility in maintenance (n=2) or peer education (n=1) and were working on the day of the interview. Fifty-two percent were visiting the medical site for specific health problems. Twenty-six percent of patients reported having family abroad in other countries,[6] although only 44% of this group reported receiving any financial support from their families.

Perceived socioeconomic status for patients was unable to be coded into quantifiable data and as such will be presented qualitatively. When asked about their socioeconomic status, patients often offered multi-faceted responses. One patient offered his sense of the general classifications of the socioeconomic levels in Haiti. He explained that there were three main economic classes, consisting of the "pov," "malere(z)," and "riche." The term *malere(z)* derives from the French word *malheureux(se)*, which literally means "unfortunate" or "poor man/ woman" (Steiner, 1988). However, in the cultural context of Haiti, and according to this patient, the term refers to a socioeconomic class one level above poverty. In my familiarity with this term, there is usually a connotation of pity and hopelessness associated with the use of the word to either self-describe one's socioeconomic lot in life or to describe another's. The patient defined this class of people as "moun kap fe efo [people who make effort]."

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[6] The Haitian diaspora's financial support of family remaning on the island was reported to be 1.4 billion in 2008, which is a significant contribution to the Gross Domestic Product (GDP) of the country (The World Bank, 2010). In addition to asking about education and occupation, I also asked about support from family living abroad to obtain further information on participants' socioeconomic status.

The term *riche*, or rich, appeared at the top of this patient's economic hierarchy, with the difference between the poor and the rich being essentially "the people who have" and "the people who have to beg."

Other patients gave similar responses, indicating that they were in the class that made some kind of effort to live without needing to ask from others. One participant was sure about his effort, but not about his economic status, stating, "M fe ti effo. M ka yon malere [I make a little effort. I could be a 'malere']." Where this participant lacked self-assurance, a young and confident participant asserted that he was a "student with potential to advance." The most interesting response came from an older female participant, "Depi ou pa ka chanje yon 20 dola Ameriken, sa ou ye? Ou pov! [If you can't exchange a US $20 bill, what are you? You're poor!]"

Providers tended to give less complex responses, with most identifying with a middle classification, as described above, and only one respondent indicating that she identified with the class who "had a salary, could feed their children, and send their kids to school."

In regards to racial and ethnic identification, all Haitian providers identified ethnically as Haitian and most as Black, with the exception of one provider who chose not to identify racially. Patients were not consistently asked to report on their racial identifications. While this inconsistency in the study protocol limited the possible findings, within the interviewing process, I was often acutely aware of the weight of this question in the room. For patient-participants who became visibly uncomfortable when asked to speak on their racial and ethnic self-identifications, it felt imposing and instrusive to insist that they respond to the question. As Zephir (2010) comments, Haiti does not subscribe to classification systems for race and ethnicity. Dubois (2012) remarks on the decision of one of Haiti's revolutionary and constitutional leaders, Jean-Jacques Dessalines, to singularly classify all Haitians as racially black. My own sense of anxiety

when asking this question of participants could be explained by my awareness of this fact and a general discomfort with imposing upon participants an American value of categorizing populations of people. Of the four who were asked, one indicated that he does not identify racially and the other three identified as Black. Four foreign providers identified as White and one identified ethnically as Pakistani.

Qualitative Data

The findings from the focus group as well as the final 43 individual interviews with patients and providers are detailed in this section, organized by the most salient themes from the analysis.

Perceptions of Providers

While patients and providers expressed many different views about all providers, among the discussions emerged a few themes: Foreign providers' role in Haiti is often short-term, foreign providers should only be selected to offer specialty care, and Haiti does not lack qualified general health practitioners. There were a few references to this among a few providers in both phases of the study.

Kadir, a focus group participant who is a critical unit physician and who volunteered in Haiti three months after the earthquake, expressed concern that his contribution to delivering care was not enough to address the chronic medical conditions that patients tended to have. He asked during the interview, "But am I really making a big difference?" He emphasized prevention as a way to temper the progression of chronic illnesses, like diabetes, hypertension, and high cholesterol. He went on to provide recommendations for building a sustainable health system in Haiti,

> But the main issue is that the major long-term problems can not be fixed by a new physician coming from a church group or other community activists groups and some

> going for weeks and some going for a few days and then going six months later again. It's not a sustainable system. Having some institution over there that you work with and you have these local physicians who then keep these complicated patients on the side for the specialists doctors coming in to help those cases, that's probably a better system that can be created through that than rather the one who are going in.

However, John, a prosthetist, who like Kadir had also volunteered three months after the earthquake, and had had previous experience responding to international disasters, felt differently,

> …at least they knew, at least they had some sort of diagnosis that they could then be educated to go somewhere else with…so you may be understating your [speaking to Kadir] impact I think a little bit. You know they could at least go to another clinic and say here's my prescription, I had this at least and then they at least know what to tune in on.

John felt that Kadir had underestimated the contributions of foreign providers, particularly those on the trip that they participated in together. He felt that patients were serviced by having some information about their health, even if they could not benefit from follow-up care with the same providers from that trip.

In phase II, non-Haitian providers expressed similar concerns about sustainable systems of care and long-term outcomes for patients. Barbara, a seasoned nurse who had volunteered in Haiti at least three times before her current three-day trip indicated,

> …I feel that we do a really well job, and that we help a lot of people. We really help a lot of people. But I think that we're just kind of, sometimes kind of just putting a band aid on certain things. We're not able to follow up with people because we don't come that often…. So I do the best I can with the stuff that we have. And we do feel good about when kids leave and stuff, and they're put on the proper medication to take care of their problem for the time they're here.

Barbara echoed some of Kadir's concerns, but like John, felt satisfied with the few services she could provide.

Table 2[7]*. Data Summary: Perceptions of Foreign Providers*

	Patients *(n=23)*	**Providers** *(n=22)*	**Total** *(N=45)*
Short-term visitors	4% (1)	18% (4)	11% (5)
Need for specialists	-	14% (3)	7% (3)
Do what they can	-	14% (3)	7% (3)
Hold misperceptions of Haitian Providers	-	14% (3)	7% (3)
Incompetent	-	5% (1)	2% (1)
Concerned about F/U	-	18% (4)	9% (4)
Malpracticing	-	5% (1)	2% (1)
Overall Positive	9% (2)	18% (4)	13% (6)
Give better care	9% (2)	5% (1)	7% (3)
More competent	-	5% (1)	2% (1)

A pediatrician who accompanied Barbara on this volunteer mission, and who had also traveled to Haiti many times before this trip to deliver health services, also reported a concern for follow-up care of patients. Suzanne maintains that she tried to inform patients that they should follow care with her during the course of her stay, if needed. And on the day of the interview, she stated, “And there’s several patients I’ve seen already twice and may see again today.” In addition, Suzanne, along with a network of other foreign providers in Port-au-Prince, had established a system of care for patients after her time in Haiti,

> And then use [names team leader] connections with who will be willing to see them for – trying to give them names and information so that there is potential follow up….If they have a major issue or problem, we can usually at least potentially get them somewhere

[7] Totals along the Y axis for all tables in this chapter are not cumulative and represent general themes from the focused codes.

> for further evaluation and management. And then once they're in the system, I'm a little more confident that they may have better continuity.

Suzanne referred her patients to more permanent foreign health providers in Haiti for long-term care.

Among Haitian study participants, a few participants believed that foreign providers have a misperception of Haitians and Haitian health professionals, often underestimating the capacity and skills of Haitian providers. One Haitian doctor, Fritz, expressed this belief as well as other strong opinions when asked about his experiences with foreign providers in Haiti. He states, in reference to expatriates of other countries,

> I don't see why….we have expatriates who are nurses…. Why do we have expatriates of general medicine? We are not lacking those in Haiti. There are a lot of nurses who aren't working. There are a lot of doctors that need work. We don't need those expatriates. And we don't need incompetent expatriates either. There are a lot of them, most of the time, they are very, very incompetent. I have the impression, that this is a special selection they made to send incompetent people to Haiti. It is a problem. Eee, huuuh, I think that we need expatriates that are really, really [the kind of] professionals that we lack. We don't need expatriates of gynecology, we don't lack gynecologists. But in contrary, we would like the expatriates who specialize in cardiology, neurology, the things that we know we don't have, and we could take advantage of. But giving us these low level staff, so called nursing staff, people who have failed in their country, at this point it is not even that we don't need them, they [just] don't need to come.

Fritz appeared frustrated with the abundance of health care providers from other nations practicing in Haiti, who in some instances were not more capable than the native practitioners of Haiti. He expressed a concern about the high competition for employment and the unmet needs for skilled specialists in fields like cardiology and neurology. Fritz went on to explain that the vast presence of "incompetent [foreign] providers" was due to a lack of Haitian authority in the society to curtail the amount of providers who enter the health system. He points to the Haitian diaspora, and those Haitians who desire to leave Haiti specifically, as a culpable group,

> It is because, collectively, we don't take our authority by the hand…. And the real problem is, that is, as soon as this happens, Haitians stop being Haitian. This is where the problem is in Haiti. That means that there is this feeling, you get this impression that the people desire other people than Haiti. They desire, they desire to leave Haiti even… They start not to like Haiti anymore. Maybe, maybe it's when they are abroad, they pretend to like Haiti…I believe that, if this weren't the case, I believe that there would be an uprising, an awakening, there might even be a revolt. As long as they can live abroad, well they have the US and Canada absorbing them, they'll forget it. They give birth abroad, they have kids abroad. Everyone feels they are well….

Fritz attributed the absence of authority to the satisfaction of Haitians with privileges obtained in other countries. He appeared saddened by these nationals disregard for their native land. He maintained that he and other Haitian colleagues were "hurt" by the influx of foreign providers after the earthquake and would prefer for, "…foreigners to visit us, we would like to see them come, come to the country, come enjoy the beauty of the country…." Fritz's sentiments about the need for specialists and the capacity of Haitian providers appear to complement those of Kadir's.

Fritz was not the only Haitian provider to report unfavorable views of foreign health professionals. Another Haitian doctor, Geraldine, maintained that she had had a disturbing experience once working with a Brazilian doctor who practiced in questionable ways. Geraldine described a negative experience with foreign providers that she was able to resolve on her own, maintaining,

> Oh Yes! I worked with a foreign provider. He was a Brazilian; and I had a bad experience with him because at that time it was in public health that I was in. They had sent him to this area, *Berluet*, in the northwest….now you know that a syringe is not supposed to be used on two people. To my great surprise, when I arrived on the grounds, I found this Brazilian who was using this syringe for an operation, without sterilization...I personally wrote to the Ministry of Public Health; the Ministry of Public Health came and removed him.

Luc, a Haitian medical intern, indicated that his experiences with foreign providers were usually short and was better captured as an exchange of information and knowledge.

Luc, like a few other Haitian providers, described his relationships with foreign providers as collaborative and beneficial to the patients they served. Suzanne, an American pediatrician, indicated a similar experience with her colleagues on previous mission trips, stating that although she did not have as much information about the illnesses she faced among patients on her trips to Haiti, she felt comfortable asking other more knowledgeable providers for help.

Table 3. *Data Summary: Foreign Provider Relationships*

	Foreign Providers *(n=5)*	**Haitian Providers** *(n=17)*	**Total** *(N=22)*
Overall Positive	80%(4)	35% (6)	45% (10)
Collaborative	40%(2)	18% (3)	23%(5)
Communication problems	-	18%(3)	14%(3)
Negative	-	18%(3)	14(3)

Kadir and John also felt that they had worked collaboratively with Haitian providers, and in once instance were "shocked" to learn that their Haitian colleagues were living in similar conditions as patients after the earthquake,

> She was like so upbeat. This nurse was so upbeat. She was keeping everyone energetic and she had no home. She was on the streets. And she was clean and nice, and well-taken cared of. I actually took a picture of her... on bad days, I want to go and look at those pictures and say, "this is professionalism." That nurse was probably one of the most professional person you'd probably ever come across, without a home, without shelter, smiling and a beautiful smile…

They expressed surprise in the nurse's ability to maintain a professional and pleasant attitude in spite of her circumstances.

Additionally, although a few Haitian participants reported positive perceptions of non-Haitian providers, as either colleagues or providers, a few also mentioned problems with

communication given the language barriers. Some patients felt that foreign providers offered better care and medicine. Chantale, a patient, states,when asked about her experiences receiving care from foreign providers,

> Hmmm! …You get more care from the foreigners, you get more care. Like…like me who keeps getting sick with this hypertension, …the hospital of Doctors without Borders, if I don't have money, when I go there, they do everything for me. I go for an operation without paying a dime. They'll give me medications, they'll do sonograms, everything without paying a dime, without a dime, but the Haitian, for them you have to give money, you have to give money.

Chantale reported receiving free health care from foreign providers, which led to her perception that foreign providers offered more care than Haitian practitioners. One doctor, Nickson, felt that foreign providers were more competent, "But in general, foreign doctors know way more, [they] have more compassion for the Haitian…." Although, he felt they may also hold some prejudiced feelings about Haitians.

In regards to Haitian providers, most foreign health care providers reported what they felt were positive interactions with Haitian health professionals. Barbara, an American nurse offered, when asked to describe her relationship when working with Haitian practitioners,

> Actually a really good relationship. And I work with one Haitian provider, and he was – he seemed pretty Americanized, and he was very kind and he was very soft-spoken, he was very gentle and he was a very hard worker. He was just an amazing man, and he just treated the people so well. It was a great experience.

Barbara reported having an enjoyable and admirable experience working alongside a Haitian practitioner. Following this statement, Barbara elaborated on her use of the term "Americanized," indicating that,

> He was – he just seemed to be more, practicing more American medicine, so to speak. More up to date on everything – I'm not sure if Haitian – I don't – I've never worked with another Haitian doctor, so I figured that they're limited for certain things. And he seemed to know a lot about procedures. Yeah. And all the medications and all that stuff. Which I know that they're everywhere, but – and I think he lived in the States for a while.

Barbara was uncertain of how to describe or what to attribute the Haitian doctor's practices and knowledge to, but appeared to feel that he was competent in his delivery of care.

In her interview, Suzanne discussed the advantages that she felt, based on her experience in Haiti, Haitian providers had in delivering care,

> I've been fortunate enough to work with some patient providers that I have thought they're phenomenal and I'm enjoying their company and they have the same approach. I actually haven't worked with anyone that I feel is so overtly different, although I think that they obviously understand the culture more…. those nuances are just easy for Haitian doctors because they understand the culture and I don't. I'm trying to understand the culture. I want to understand the culture, but obviously, I've only been here five times. So I don't.

Suzanne felt that although Haitian providers practiced in a similar fashion, she did not understand the culture as well as Haitian providers. Of note, this interview took place on the second morning of the team's three-day stay in Haiti. The day before this interview, I served as Suzanne's interpreter with patients. The "nuances" that Suzanne refers to in this excerpt is in reference to a potentially negative interaction between Suzanne and a Haitian nurse that I cautioned Suzanne against. Witnessing a brief exchange between another foreign provider on site and the Haitian nurse about the Haitian nurse preferring to sit and conduct intake of patients, instead of assisting other providers, Suzanne jokingly stated aloud that the nurse was being "lazy" and indicated to me that she planned to tell her so. I quickly warned Suzanne not to make such a joke and explained that the word itself is culturally loaded and would be highly insulting. Although she did not completely understand, she refrained from making the joke.

Table 4. *Data Summary: Participants' Perceptions of Haitian Providers*

	Patients *(n=23)*	**Providers** *(n=22)*	**Total** *(N=45)*
Skilled/Competent	-	18% (4)	9% (4)
Have an advantage	-	9% (2)	4%(2)
Overall Positive	30% (7)	18% (4)	24% (11)
Negative	39% (9)	9% (2)	24% (11)
After God	22% (5)	14% (3)	18% (8)
Don't uphold cultural beliefs	17% (4)	18% (4)	18% (8)

In their evaluation of Haitian providers, patients generally perceived Haitian providers to be working well at their respective sites. Many indicated, when asked about their perceptions of providers, "Wi yo travay trè byen, yo travay trè byen [Yes, they work very well, they work very well]." And another participant, Ronald, stated matter-of-factly, "Well, everyone, all the doctors, work well. The patient comes, the doctor prescribes, and the patient buys the medication. They're very good." To Ronald, and many other patients, receiving a prescription for medication during a consultation with a provider was critical to the visit.

Nadia expressed the same feeling but also reported a concern about Haitian doctors practicing outside of their specialties. Nadia explained that the mistrust between patients and providers at her medical site may come from the problem with doctors attempting to treat patients outside of their area of medical knowledge. She later in the interview gave a strong recommendation to doctors to remain in their field of practice.

To gain more insight into patients' perceptions of Haitian health professionals, patients were asked to comment on any advice that they would like to give to providers taking care of them at their site. A few patients appeared reluctant to answer this question, bashfully indicating

that they were not in the position to offer advice to knowledgeable doctors. Among those who did answer, the answers that reflect the most frequent responses, and reveal some information about their perceptions of providers, are listed below:

> … the advice is, for them to be more centered on what they are doing. To not be discouraged no matter what. They might find problems, difficulties, because all institutions may have a little problem, but they have to take that by the hand. They can't pay attention to that, they can't be discouraged with patients, because in this way they are very…how do you say, sometimes, they cause a little problem. When the person doesn't come to their appointment, and you do an exam for them and you can't find them, in this sense, for them not to be discouraged. In addition, for God to grant that more life so they can continue to give care…
>
> \- Marie-Solange

> The advice that I would give them at the hospitals, for them to give good care. Like, when the patients come to the hospital… for them not let them die, because a lot of [cases] when patients come to the hospital, they leave the person. They laugh, they tell jokes among them, they leave the person out to die. And the person is sick to death and they don't even see him….I would give them advice to take care of patients…. If the person were well…if he didn't feel that he were sick, he would have sat home. It is because he does not feel well that he came to the hospital. I'm asking them… to give good care, give them good service.
>
> \- Chantale

> Well, what advice could I give them? Me, when I'm praying to God, I always ask God to give them intelligence, to give them the spirit of understanding for them to understand what they are doing. And for God to bless them, for Him to give them a lot of patience when a patient comes to them, for them to be able to understand how to handle them, for them to have patience with them. That's why I always pray to God for them, because there are a lot of patients who come to them [and] if they don't have patience, they won't be able to deal with them…
>
> \- Francoise

> I would wish that the doctors aren't playing favorites with no matter who comes before them, they have to take care of him, because they are human beings…as long as the patient comes for [care], it is his job. It is his job, if he can't, he should refer him to another doctor, but if he can take care of him, he should take care of him.
>
> \- Hugh

Patients appeared to approach this question as an opportunity to present a "wish-list" of desired qualities in health professionals or to discuss the grave mishappenings in their experiences in the

health system. Marie-Solange and Francoise were concerned about providers' ability to cope with difficult patients, even offering prayers to God for their patience and understanding. Chantale and Hugh, however, suggest that they had had some negative experiences with health providers in the past and had more specific advice to give to providers based on these experiences.

In addition, many participants directly or indirectly mentioned the old Haitian adage, "Apre Bondye se dokte [After God is the doctor]" to express their reliance on and confidence in doctors at their sites, when answering this question. A few doctors noted that they felt patients were eager to "submit" to their recommendations because of this perception of providers as "super-heroes." Benny commented,

> …you'll see that the patient doesn't ask for much. They say, that after God, is the doctor. Ok! So that means that, the doctor, you can do everything, you are the one who decides if what you are doing is good. That means, that it is a form of submission. That means, 'I won't insist, after God is the doctor.'

Benny spoke about patients' strong confidence in the provider and their perception of providers being powerful and second to God.

Perceptions of Patients

In phase II, at the end of their interviews, providers were asked to speak about their general perceptions of patients at their respective sites. Many gave their overall impressions and some had begun to express their feelings about patients long before this question was posed. Through the questions about illness representations and attitudes about traditional medicine, many providers offered their thoughts and feelings about patients- and their practices. This subsection begins with providers' general perceptions of patients in Haiti, followed by comments on patients' models of illness and how this affects the delivery of care. Providers' thoughts about

traditional medicine and its practice, between providers and patients alike, are presented in this section as well.

In her experience with patients, Barbara developed what she describes as a "love" for them,

> Oh, I just love them. I don't know what else to say. …I mean they're fabulous. They're patient. They're happy. …They'll sit for hours and hours and hours and just wait, and they're always – you know, you look at them and they just – they're always smiling. And they sing. They're just wonderful people. …They're happy to be here to get the treatment that they need, and they're happy that we're here for them. And it's a nice mix, you know? … Every once in a while, you'll get a couple older women that will argue with each other about who's first. But that's very rare…

She describes patients as happy, patient, and grateful for treatment, noting that very rarely did patients become disruptive. From this same site, Suzanne, a pediatrician, made similar remarks about the patient, also adding thoughts on patients' overall health,

> I think a lot of them are sick. I think a lot of them are sicker than I've seen at some other clinics. I think they're appreciative. I think they're warm and friendly, and I always love when I see some of them come in all dressed up. It's almost like they're trying – you know, they're dressing up for you, and that makes me feel really happy because it makes me feel like they appreciate us. I don't know. That makes me happy.

Suzanne expressed happiness about patients' presentation, in spite of their compromised health. She interpreted their dressy attire as a demonstration of their gratitude for providers' service. Of note, it is common to see children wearing what would be considered formal dresses in the US to medical appointments. Sometimes, however, this may be more reflective of economic positions, in which parents may not have other clothing in which to dress their children. This is sometimes apparent in the "wear and tear" of these dresses.

Table 5. *Data Summary: Providers' Perceptions of Patients*

	Haitian Providers *(n=17)*	**Foreign Providers** *(n=5)*	**Total** *(N=22)*
Overall Positive	29% (5)	80% (4)	41% (9)
Concerning	18%(3)	80% (4)	32% (7)
Uneducated	71% (12)	-	51% (12)
Poor/Underprivileged	18% (3)	60% (3)	27% (6)
Aggressive	29% (5)	20% (1)	27% (6)
Expecting of Providers	41% (7)	-	32% (7)
Believing in Malevolent/Supernatural Causes of Illness	77% (13)	60% (3)	73% (16)

In phase I's focus group, John and Kadir offered similar sentiments about patients, noting their significant needs and ability to maintain positive attitudes in spite of their circumstances. John spoke on the "smiles" of young amputees, while Kadir recalled his need to remain composed with patients in spite of their stories and circumstances, "So, you wanted to…sit down and cry with some patients." But you couldn't afford to because there was somebody else waiting for you to be seen." Kadir also remarked on the media hype he observed before going to Haiti, "So you've read about it, heard about it, and seen it on television, when you touched the patient, then you're a part of it." He commented that the experience of being in Haiti after the earthquake helped him to realize the extent of the destruction and servicing patients made him feel a part of the recovery.

When Haitian providers were asked to discuss their perceptions of patients, providers often discussed "the different categories" of patients. Educational level and socioeconomic status

were frequently presented as the defining variables for the categories. A few providers offered the same impressions that Regine states directly below,

> Generally, there are many patients, many patients in Haiti. This will depend on the education level of the person you are referring to because there are some people with whom you can spend the whole time talking about what it is, he will never understand it. Therefore it relies on you to make a decision and say "here is how, here is how, here is how;" and even sometimes you take a decision for the person in saying "here is how" and you realize that he doesn't get it. It's like you wash your hands and you put it back in the dirt, because what was important, this morning we were talking about this, there should be medical anthropology, because there a lot of terms that people are using, you yourself you don't know the terms. You're trying to figure out what these terms mean.

Regine, among several other Haitian providers remarked on their experiences of trying to help patients, listing educational levels as a problem in helping patients to understand their health. Regine recommended that medical anthropology be integrated into the training of providers to help with these kinds of difficulties.

Like Regine, Olivier, a Haitian medical intern who indicated that he chose to work at his site to gain experience with the population of patients typically serviced there, reported during the interview,

> Some patients come for purely a medical problem, and minor fever, a cold. Some come for things more complicated. And you have to understand something about the healthcare here, is that – you have to understand that most of the people in Haiti are very illiterate….That means they don't know how to read, write, and they still believe in some old mysticism. So they cannot really explain to you what do they feel or how – they don't know how to say it for you who's a doctor, who spent seven years studying a lot of complicated stuff. So you have to dig deep. You have to dig deep, deep, deep, deep, deep exactly to find out what do they mean when they have a problem.

Olivier described what he perceives as a wide educational gap between patients and providers in Haiti. He maintained that providers have to spend a lot of time understanding patients and determining their illnesses. Olivier went on to explain in his interview, which he chose to conduct in English, that he "was born fairly to an easy family" and was unaware of certain

societal problems. He indicated that in addition to his sheltered upbringing, he was not exposed to much while training to be a doctor,

> Because medicine is not easy. Okay? So you're like 24/7 studying, learning, making researches. But you don't really have time to know your countrymen. So this way, working with them face to face, I get to know them, and I get to dig deep to find a common ground. That way I can understand what they're saying.

He felt that this internship year would provide him the experience and exposure to various groups of people that would enhance his understanding of patients.

Other practitioners noted patients' behaviors, sometimes even a change in behavior over the years. Melissa, a nurse working in the maternity unit of Site Three, responded, "Patients, well especially for the ones in maternity, these patients can be a little aggressive…" Fritz, a Haitian doctor also from the maternity unit of the third site, noted the same,

> …I think there is a decline in the way patients behave, in the behavior of the patients' parents. Once, they respected the doctors more, the nurses more. But now, they are aggressive, people don't respect people. They have become dangerous. I think that it is a situation that is difficult now, and, I can't commend the patients anymore, neither the parents anymore. Maybe I have to try to see all of what has made them that way, but there is a collective anger, there is an animosity, there is a frustration in the society, that makes it that, when a person presents in an institution, especially a public institution, he/she is more, he/she has this rage, he/she has this…he/she is like a person who needs to unleash himself onto the public, onto the doctors, onto the staff. The patients are not calm anymore, they are not patient anymore.

Fritz attributed the "decline" in patients' behavior to a larger sociocultural problem. He expressed an interest in studying the phenomenon more. Echoing some of Fritz's comments on patients' anger towards health care providers, Sophia, a pediatrician at Site Three, felt that patients at times blamed providers for things that are not their "responsibility."

Annaise felt that patients in general were,

> … people who are in search of a better being… Sometimes, there are some who come from everywhere, they sometimes come from all the way downtown to come up here, because they say here perhaps, people will find a solution, perhaps when they can find us to give them something.

Annaise discussed the distance, both literally and figuratively, that patients travel to have their needs met. Annaise felt that patients at times had expectations of providers that may not have always been met.

Among the perceptions of patients that were related to education and socioeconomic status, were also perceptions of patients that were related to patients' beliefs about the causes of illness and their practice of traditional medicine.

Table 6. *Data Summary: Participants' Beliefs about Illness*

	Patients *(n=23)*	**Providers** *(n=22)*	**Total** *(N=45)*
Beliefs interfere with care	-	27% (6)	13% (6)
Caused by malevolence	26% (6)	-	13% (6)
Caused by poor hygiene	48% (11)	32% (7)	40% (18)
Caused by poor self-care	48% (11)	32% (7)	40% (18)
Caused by physical health problems	26% (6)	27% (6)	27% (12)

Many providers shared Sophia's impression that patients often believed in supernatural causes of illness, or frequently attributed their illness to others who wished them harm. Benny stated,

> Oh no! In Haiti, every illness has a malevolent approach first. Ok, by this I mean, the patient will not accept that he is sick, if he is sick, there is a reason. And he will find the reason. Most times, the reason is an accusation that he is making…in the sense that it is someone who does not like him who did this to him. It is the traditional approach. This is how the Haitian thinks first. But what I can say is that in certain spaces, we don't think like that…in the space where the person is more or less educated.

Benny, like many other providers, felt that illness representations were highly correlated with educational level in Haiti.

Even Paula, an American nurse from Site Two, had heard about common Haitian patients' beliefs about illness, stating,

> Ah! I've heard a lot about here, like voodoo, and witchcraft but it seems like most of the people that are coming in for medical attention, if they're coming in to see a doctor, they are not believing in the witchcraft, otherwise they would go see a voodoo doctor I guess you would say.

Paula appeared to feel that patients who consulted with doctors did not believe in the common illness models supported by patients. One patient offered a counter to this claim, stating, "…in the Haitian tradition, we all, all Haitians believe in this, all Haitians believe in this."

Fritz appeared to feel the same, in his statement about Haitian providers,

> There is a hypocrisy in this in this sense, a big hypocrisy. It is an effect of slavery, it is an effect of the marooning, you are always hiding what you are doing. But it is a practice that we all practice…even when we are not exploiting it, we don't speak of it too much, but on the low, low, every Haitian drinks his little [cup of] tea. Every doctor, no matter who he is, he believes in his little traditional medicine.

Fritz spoke about the discrepancy between Haitian doctors stated beliefs and their practices of traditional medicine, implicating Haitian doctors as Haitians who pretend not to practice. He further explains during his interview that Haitian doctors often discourage patients from practicing herbal methods even though they practice themselves. In the quote above, he appears to be attributing the "hypocrisy" to Haitian history, specifically naming a need for it during slavery.

However, Sophia indicated that Haitian doctors do not really support these beliefs and above all she, personally, "is a scientist before anything." She did not believe in patients' explanations for illness and in regards to traditional medicine, Sophia explained that if there were a way of creating a more "scientific" method for practicing, she would be interested in learning more. Delner, a self-described "community health doctor" who trained in Cuba asserted that such training does exist for doctors in Cuba,

> They integrated it. There was a part when they taught you …[how to] dosage. They call it "MNT," natural traditional medicine and it is a regular course, like you'll learn about physical therapy, hydrotherapy, you can learn acupuncture, so it is a regular course in the medical training.

Delner maintains that traditional medicine was well integrated in his medical training in Cuba. In spite of his training, he agreed with other participants that beliefs in traditional medicine can sometimes interfere with the treatment process, stating, "…They practice it very much, but the danger comes [when] they don't dosage the herbs." To ameliorate this, Delner maintained that he supports patients' use of herbs and he often tries to teach them about the proper dosages, particularly for patients who are also taking pharmaceutical drugs. He reported that he, "…marye yo ansanm, m marye yo ansanm [I integrate them, I marry them together]."

Table 7. *Data Summary: Participants' Beliefs about Traditional Healing*

	Patients *(n=23)*	**Providers** *(n=22)*	**Total** *(N=45)*
Practiced before/instead of/after care	57% (13)	5% (1)	31% (14)
More affordable	9% (2)	-	4% (2)
More effective	9% (2)	-	4% (2)
Supports patients use	-	36% (8)	18% (8)
Incorporates into practice	-	5% (1)	2% (1)
Doesn't support patients use	-	18% (4)	9% (4)
Sees problems with it	-	27% (6)	13% (6)

Geraldine, a Haitian nurse from Site One, also supports patients' practice of traditional medicine,

> No, no, I never discourage them in using herbs, in traditional medicine. This depends on what the patient tells me he has; but if it is something that I do not have any explanation for, I won't encourage him; I'll say, 'Ah! I'm sorry, I don't know anything about it.'

Geraldine felt that her support of it also depended on patients' medical conditions. She later explained that she felt patients believed in these practices because they have found that it works for them, specifically, they have found "results." She supported their practice as long as patients believed that it worked for them.

Suzanne provided a similar response, further explaining that supporting patients in this way could also benefit the doctor-patient relationship,

> And as long as it doesn't do harm, I'll support it. And I wouldn't necessarily argue the point with a patient. I think there's really this fine line you have to draw because you want to have them trust you. You want to have them see that they respect you. So if they have a strong belief, and you say, "No, that's entirely wrong," you're not respecting them. So therefore, whatever else you say after that, they're not going to listen to as readily.

Suzanne felt that supporting patients' beliefs was a sign of respect and promoted mutual trust and cooperation with patients.

However, Benny like a few other Haitian providers, still felt that it was an issue in the health system in Haiti,

> This is really, really the biggest problem that we are facing…you will see that the 50 year-old, 60 year-old, he'll say, "doctor this is the first time I've come to the hospital," you'll see that he always knew, he had the headache, he was taking "vetiver," he has a cold, he's taking "langichat" herbs, he has a fever, he's taking "asosi." So with that, he's not coming down to the hospital, especially with the way the country is, hospital centers don't go find him. They have to come to the hospital, hospitals don't go to them. So there is a distance that the person is coming from, he won't come, he won't come. So he prefers to stay with his traditional medicines.

Benny discussed the delay in patients receiving care, some waiting a very long time in their life to ever visit a hospital. Nicole, another Haitian doctor, felt, "It is very hard to remove a lot of taboo, a lot of taboo, from their minds. So they stay practicing what they know. And when they come to the hospital, they come too late." Nicole expressed a concern for the delay in patients' receiving vital care, which she attributes to the patients' beliefs in traditional medicine.

When asked directly about their beliefs about illness, many patients gave the responses that providers' indicated, in addition to identifying poor hygiene and poor self-care. Some named germs and other physical health problems as well. Francoise, a patient, indicated,

> Illness sometimes comes from a lack of hygiene…sometimes all of this comes from a lack of self-care, because if you are suffering from hunger, that will make you sick. And especially for, what they call "gas," that is what they call having a weakness that will affect you mentally and visually.…when you lack self-care it draws on sickness, even though you have to be sick, you have to suffer, because Jesus Christ himself suffered….

Francoise gave multiple causes of illness, including poor hygiene, lack of self-care, specifically hunger. She ultimately decided that illness is inevitable, and like Jesus Christ, everyone must suffer.

After describing their beliefs about illness and healing methods, patients were then asked to talk about if and how they spoke with providers about their practices and beliefs. Marie Jocelyn offered,

> Well, when I tell him this, he doesn't take it seriously, because he knows that we Haitians, we believe in what is called the herbs a lot. So when we are sick, we believe more [in this] first. Before we run to find a doctor, [we] go to the tree where we will find a solution.

Marie Jocelyn felt that providers were aware of her practices and also explained that patients sometimes choose their own remedies before consulting with a physician. Rose describes a different experience, "Yes, yes. They tell us not to boil herbs, [like] don't do this, because, they say a lot of stuff that I'm not interested in. They don't believe in it." Rose felt that Haitian providers were discouraging of herbal remedies because they did not believe in them. She chose to ignore them instead. She also explained,

> Well, when I don't feel well, and I don't have money to come to the hospital I drink tea, I boil herbs, I boil water and with a little sugar, a little salt, when I'm done I pour it in a cup, wash the leaves, put it in there, steep the tea, I take it, and I rest until I have the means to go to the hospital.

Rose suggested that her choice to follow traditional methods were also due to economic reasons. There are times when she can not afford to go to a hospital and must take herbal medicine to self-treat her illness. Martine also reported taking herbal medicine before seeing a doctor. Martine later explained, in regards to the efficacy of prescription drugs versus herbal medicine, "…the medicine the doctor gives works faster. What we make for ourselves lasts longer."

Provider-Patient Relationships

Despite conflicting beliefs about illness and healing methods, both providers and patients reported having "good" to highly collaborative, understanding, and close relationships with each other.

Table 8. *Data Summary: Relationships with Haitian Providers*

	Patients *(n=23)*	**Haitian Providers** *(n=17)*	**Total** *(N=40)*
Overall Positive	91%(21)	12% (2)	9% (23)
Collaborative	4%(1)	47% (8)	23%(9)
Comfortable Communication	30% (7)	12% (2)	23% (9)
Supportive	39% (9)	29% (5)	35% (14)
Communication Problems	22% (5)	82% (14)	48% (19)
Understanding	-	35%(6)	15% (6)

In general, patients expressed satisfaction with the care they received at their respective sites, many feeling supported by providers. Patients from Site One and Three, reported this the most. However, the director of the HIV/AIDS program from Site One attributed the positive relationships and patients sense of support to the successful funding of the program,

> But, you'll see that it is very different…because it is extremely important, because this AIDS project receives special financing, 'so they take special effort for patient,' they take

> a lot of …. 'fund to take care of the patient. Ok? More services are free, the medication are free. It's different for the other people, for other patient, you have to pay, you have to buy medication'

The director highlighted the differences between care for patients living with HIV/AIDS and those not enrolled or participating in the AIDS program at the hospital. When funding is available, patients receive better care.

Communication between providers and patients was another salient issue that was often associated with patients' socioeconomic status and educational levels. Several Haitian providers indicated that although they would like to practice a more patient-centered manner of care, this is not always possible with certain patients. Regine maintains in regards to her interaction style,

> …this depends on the patient, because even if you tell the patient that, there are patients that come, that are not good at all. When I say not good at all, it's in language. So if I can't, even if you explain to the patient a 1,000 times, you would need a psychologist to speak with the patient, speak to the patient, before he can understand.

Fritz also felt that doctor-patient communication is a problem in Haiti,

> But the reality is that in Haiti, there is a problem, a problem of communication. And there is a doctor-patient communication problem. And this problem, it has many factors in it. It has an educational factor, that means, the patients are more often people who are uneducated. That means a person who doesn't really know how to read, or how to understand. And the doctor himself, in his training, they didn't teach him how to get down to the patient's level.

Fritz attributed the communication problems with patients to a lack of training in medical school. Not all providers felt that it was the responsibility of medical schools to train doctors in communicating with patients. Delner felt that it was the responsibility of the provider practicing in a community to understand the patient. He emphasizes the "right" of patients to speak in a manner that is most comfortable to them and tasks the provider to help remove feelings of fear and inferiority from the patients. Delner offered,

> Well! …you have to get into the language of the patient. That is what is called a community doctor, that is what is called a public doctor…that is what is called a family doctor; for you to understand the person's language, you have to enter into the person's culture, you have to enter into his world, because he has the right to come and explain something to you that you don't understand. But you have to try to understand what he is trying to say to you…especially because in Haiti, now it's starting to change, but other times, the patient used to always be scared to explain what is wrong. …He had a feeling of fear, a feeling of inferiority…

He notes some recent change in these attitudes in Haiti. Marjorie, a nurse from Site One, makes a similar plea on patients' behalf,

> The people like someone there to speak to them, to explain, to explain to them what to do. To give them ideas on [their] illness. Very often, the person has a problem, they don't explain to the person what he has. The person needs for you to explain….he needs an orientation. He needs someone to listen. He needs someone to guide him.

One patient had the same request,

> …more kindness because…we need this, because there are of us who didn't find love in the places that we lived. Well, there are times you wish to leave your house to sit with someone who knows you to talk, because there are times when you feel like your head is heavy.…more kindness, more understanding, so that they can understand us, so they can understand.

Louise replied earnestly when asked about the advice she would give to providers. Simply, she asked to be cared for, understood, and heard.

Perceptions of Health Services since the Quake

There were a few prominent themes from participants' responses regarding their perceptions of changes in the health system since the earthquake. While some participants indicated that they did not observe any changes in health services after the earthquake, some described a few differences. Many patients noted that there were many more foreign providers available offering sometimes free and easily accessible services in tents in the quake affected areas. Francoise, a patient from Site Three recalls,

> Have I seen a change since the earthquake? I have seen since the earthquake. I saw them walking around to give medication, and children who needed vaccinations got them, and [they] gave the people medication.

Francoise observed that there were foreign health care providers offering medication and vaccinations to patients living in the provisional tent homes, where hundreds of thousands displaced earthquake survivors resided after the event.

Table 9. *Data Summary: Participants' Perceptions of Health Services*

	Patients *(n=23)*	**Providers** *(n=22)*	**Total** *(N=45)*
More doctors in Haiti	35% (8)	5% (1)	20% (9)
No change in services	9% (2)	18% (4)	13% (6)
Interruption of services	13% (3)	5% (1)	9% (4)
More human	4% (1)	14% (3)	9% (4)
Cholera	4% (1)	5% (1)	4% (2)
Patients have more needs	-	9% (2)	4% (2)

One provider remarked on the cholera epidemic and a couple discussed an increase and difference in the types of needs patients had, some requiring more attention or psychiatric services. Nickson noted that patients' circumstances since the earthquake required more consideration during consultation,

> …After the earthquake, instead of the person only…you have to consider his entourage as well, because you know that person had people…there were people who lost their whole family…before, you weren't interested in all of that…you didn't consider all of that…you were a little more impersonal.

Nickson observed that after the earthquake, providers became more personal and more interested in learning about the patients' lives and families, expressing a concern about how the patients and their families survived the quake. A few providers also noted that there was a desire to become "closer" and more "human" with patients after the earthquake. Caroline, a Haitian nurse

from Site One stated,

> Ok the way you communicate with them, like I became, like I felt I became closer to them, I became closer to them, like, I gave them more of myself, more of my time listening to them. I take more time to share ideas with them, to understand them, to try to listen to them. Make the person more or less understand themselves again.

Caroline discussed a desire to become more familiar with and offer more to patients after the earthquake. She felt that this would be of service to them as patients attempted to regain a sense of self.

One patient, Hugh, perceived the earthquake to be a leveling incident. Hugh felt that the earthquake had changed the perspectives of those affected, particularly more for those who had separated themselves from others before the earthquake,

> …in the moment of the earthquake, we saw a series of people who did not care about money, who cared for people's lives, who attempted to give their all…and them too, they could have been in the situation because there were a series of doctors, who died in Port-au-Prince, professors who died, there were all kinds of people who died in the earthquake…people who pretend not be friends of a certain type of person, they came to see that that wasn't there, because when you saw the grounds of Port-au-Prince, Jacmel, and Leogane, you saw all the people under the rubble….after the earthquake there has been change. People came to see that no matter what your status is compared to another, they see that they have to partner with you.

Hugh commented that the earthquake appeared to equalize the population as everyone became affected by the destruction and the loss of lives.

Results Summary

Participants for this study were mostly patients (after excluding one interview) who on average were older than the providers. Both patient-participants and practitioners were mostly female. Patients tended to live far from their respective medical sites, with over half living up to three hours away.

All Haitian participants spoke Haitian Kreyol, with most patients who were asked about literacy reporting that they could read and write in Kreyol. Providers tended to be more fluent in more languages, including French, Spanish, Kreyol, and English.

Half of the patients were at the hospital on the day of the interview for specific health problems, or "sick visits." Three were employees of the hospital and were working on the day of the interview. Most patients were employed in various kinds of work, like merchantry or agriculture, and had also obtained at least a secondary level of education. Under half reported receiving financial support from family members living abroad. Of providers, participants were mostly general physicians, with about a third being in practice for five years or less. Most providers perceived themselves to be in a middle socioeconomic range. Patients, however, appeared to shy away from identifying with specific socioeconomic classes, preferring to describe instead their effort to maintain a decent livelihood for themselves and their families.

Findings from the qualitative analyses revealed the following main themes:

- Both Haitian and foreign healthcare providers reported concerns about the role and place of foreign practitioners in the Haitian health care system. Some providers felt that the role of foreign practitioners should be limited to providing specialty care and training in special medical areas, in which Haitian providers are less knowledgeable. Although just a few providers spoke about this issue, this is presented as a salient theme because it appears as an issue that has not been sufficiently discussed in the current literature. A few participants also expressed a concern that foreign providers held prejudiced ideas about Haitians.
- Providers hold strong views about patients, which for Haitian providers, were often related to education and socioeconomic status. Foreign providers expressed

overall care and concern for patients, including concern about their follow-up care, given the short-term nature of their role in health service delivery in Haiti.

- Patients are appreciative of the services received from both foreign and Haitian providers, although a few perceived foreign providers to be more informed and Haitian providers to be less patient and compassionate. Yet, patients and providers believed that patients tend to perceive providers, particularly doctors, as heroes or second to God.
- Both providers and patients felt a conflict between believers and practitioners of traditional healing methods and representations of illness, with most patients expressing beliefs in both modern and traditional methods and a range of beliefs about illness, while providers tended to side with their modern medical training. A larger cultural hypocrisy around this issue in Haiti was named.
- Communication, often viewed by providers to be related to patients' level of education, was identified as a significant problem within the provider-patient relationship. Haitian providers mentioned language barriers and the inadaptability of their training textbooks to the patient populations they serviced. A few providers felt strongly that providers needed to learn how to adapt their language to better service patients.
- In regards to perceptions of health services since the earthquake, many participants observed changes that included 1) an increased presence of foreign health care providers who offered free and easily accessible services, 2) changes to patients' needs such as a need for more attention, consideration, and

understanding, and 3) a change in providers' approach with patients, a few indicating that they became more "human" after the earthquake with patients.

Data were collected for all four primary research questions, with some themes emerging stronger than others. In the next chapter, the interpretations of the findings are presented, followed by the implications and recommendations for future research and health care practitioners. The chapter ends with the limitations of the research and conclusions.

Chapter Five: Discussion

At a TED conference in 2004[8], famed Haitian-American novelist Edwidge Danticat spoke on the complexities of Haitian history and culture, while presenting excerpts from some of her most award-winning and seminal literary work (TED, 2010). She informed the audience of the significant contributions of Haitians to not only Haiti, but also to the expansion of the western world since the Haitian Revolution over 200 years ago. Before beginning the readings from her own novels, Danticat explains to the audience that it is common and important in Haitian culture to present transitional statements before beginning a new topic in conversation, citing the well-known Haitian story-telling call and response, "Krik! Krak!," as an example. For this chapter, an excerpt from classic Haitian novelist Jacques Roumain's *Masters of the Dew* [*Gouverneur de la Rosée*] will serve as the transitional statement for the interpretations and applications of the study findings.

> What are we? Since that's your question, I will answer you. *We're this country*, and it wouldn't be a thing without us, nothing at all. Who does the planting? Who does the watering? Who does the harvesting?....Yet with all that, we're poor, that's true. We're out of luck, that's true. We're miserable, that's true. But do you know why, brother? Because of our ignorance. We don't know yet what a force we are, what a single force-all the peasants, all the Negroes of plain and hill, all united. Some day, when we get wise to that, we'll rise up from one end of the country to the other. Then we'll call a General Assembly of the Masters of the Dew, a great big *coumbite* of farmers, and we'll clear out poverty and plant a new life (Roumain, 1944/1947, p.75).

The *Kombit*[9] of Patients and Providers

In my experience, the Kreyol term *kombit,* meaning collective work for a common goal (Smith, 1999), is often recalled or used when anyone refers to Haiti or Haitians. It is almost used

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[8] I had the honor of being corrected by Danticat herself at an event featuring the writer in New York in March 2013! Danticat explained to me that this lecture was originally filmed at the University of California in 2004 and was later posted onto the TED website in 2010. I assured her that the correction would be noted in this document.

[9] This is the Kreyol spelling for its French derivative *coumbite*.

as often as the word *resilient*. Being a member of a *kombit* or someone who initiates a *kombit* is highly valued in Haitian culture, particularly among the economically and racially marginalized population of Haitians in Haiti. When a *kombit* is formed around a specific goal, it often serves dually as a political body and a working group of the underprivileged (Smith, 1999), and also promoting democratic values (Fatton, 2000). It is, perhaps, a form of Haitian communal advocacy inherited from a preserved cultural system of West African ancestry. It is, for certain, a resource of the nationally disenfranchised.

In his classic work, Roumain attempts to give insight into the lives of the *paysans*, or peasants, of Haiti. In the passage above, the protagonist of the novel, Manuel, has just returned home from Cuba, after many years of having been apart from his family who remained in a very rural and small area of Haiti. Already feeling slightly defeated yet determined to improve the agricultural sector of his family's community, Manuel's friend, Laurélien, comes by to visit and asks about his time in Cuba. The friend approaches Manuel uninformed on the differences between Haiti and Cuba, specifically discussing the opportunities for "Negroes" in Cuba compared to the lack of opportunities in Haiti. Laurélien, also feeling discouragement and the brunt of social injustice in Haiti, asks Manuel directly, "What are we us peasants? Barefooted Negroes, scorned and mistreated" (p.75, Roumain, 1944/1947), to which Manuel offers his fiery and lengthy quip. While recognizing that for the zeitgeist of Roumain's highly acclaimed contribution to Haitian literature that the term *kombit* is used appropriately, it is proposed that for this discussion the reader reconsider the concept of *kombit* and who this group typically includes.

A few participants of this study suggest that after the earthquake a collective was formed, which included Haitians, foreigners, the poor, the rich, the informed, and the less informed. And according to one patient in this study, this same collective worked towards a common goal: to

save as many lives as possible- physically, spiritually, and psychologically. There was a role for everyone and due to the intensity and urgency of needs after the quake, these roles were, for the most part, quickly defined and adopted by everyone who chose to be involved.

However, as those who were involved are learning now (PAHO, 2011) and has been learned through this study, some of these roles were not always appropriate. Both foreign and Haitian providers in this study spoke on the limitations of foreign providers in offering services. They mention the temporary presence of foreign providers and of the duplication in services or skills, as some interviewees felt that foreign providers were more needed for specialty care than the general services that Haitian practitioners were available to provide. Yet, it seems that there remains a place for each actor. Perhaps, each actor can have a role in the *kombit* once there is a better understanding of the dynamics at play within these relationships.

Relationships between and Perceptions of Patients and Providers

As was reported earlier, Olivier, a Haitian medical intern at the first site, explained that prior to becoming a doctor, he was not exposed to the population of people that he encounters in his current work at the site. He further explained how this lack of exposure became problematic in his communication with patients who spoke Kreyol in a way that he could not understand. He mentions that his “fairly easy” upbringing coupled with the fact that there is “no time to know your countrymen” when studying to be a doctor, often caused frustration and disappointment in his attempt to understand patients’ language and models of illness. Because he often could not relate to patients, he felt frustration when patients chose their traditional healing practices or “mystic” explanations for illness.

Many Haitian providers, whether from Olivier’s same socioeconomic background or not, spoke about not knowing or not being trained in how to communicate with patients. They

explained that they were trained in French (or Spanish for those trained in Latin American countries) and with French textbooks that were not adapted for the populations that they actually serve. Providers' identified difficulties in building relationship with their patients appeared to also bring to surface their loaded and complicated perceptions of patients.

Two main percepts of patients were frequently presented during the interviews with Haitian providers: 1) Some patients are educated and some patients are not and 2) the patients who are educated understand things and do not need much explanation, and the ones who are not educated need lots of explanation and support. This seems to reflect the dichotomous social organization, or hierarchy that exists within the culture itself, to which Roumain also speaks of through his characters in *Masters of the Dew*.

The multiple "worlds" of Haiti have been well documented and of great interest to many who find the economic divide between the "elite" class and 90% of the rest of the population fascinating. Dupuy (2012) notes, that between 1976 and 2007, the economic disparities in Haiti have remained almost the same, with the most affluent members of the society possessing just under half of the nation's wealth. This minority, yet powerful, group is noted to have formed shortly after Haiti gained independence in 1804 and was further empowered by the US after its occupation of Haiti in the early 1900s (Farmer, 2011).

In her study of doctor-patient interactions in family planning clinics in Haiti, Maternowska (2006) makes note of the impact of classism on doctor-patient relationships reporting, "issues of power, authority, and class imbue every aspect of the client-provider interaction" (p. 94). This quote brings to mind Benny, a provider in this study who discussed the perceptions of providers as powerful and second to God. Both Maternowska and Benny contend

that providers have a great amount of power in doctor-patient relationships and this power differential should be considered seriously.

Delner, the Cuban trained physician from Site One, spoke about “the fear” and “inferiority” that patients in Haiti have felt in their interactions with providers. It could be argued that the shy, reluctant, and overly gracious tone of some patients in this study may have been related to these feelings, although culturally politeness is highly valued (Nicolas, Schwartz, & Pierre, 2010). Still, while some patients spoke directly about the injustices that they have witnessed or endured within the healthcare system, many gave responses that reflected an internalized blame and shame of each other. When asked to give advice to providers, a few asked for providers to “forgive” patients who misbehaved, almost pleading for providers to be “patient.” One participant offered a religiously laden rationale for suffering in her response to illness stemming from a lack of self-care- like starvation. Religion and spirituality may be facets of the resilience that Haitians are known for, but it certainly should not be the basis for anyone’s argument for, essentially, structural injustices.

Of the uneducated patients described by providers in this study, some providers spoke disdainfully about patients’ ignorance and how their beliefs made “the doctor’s job hard.” Olivier even offered his recommendation, “Well they need education. I think it is the first- that is going to make the job of the healthcare provider a lot easier, if they stop believing in the mysticism.” These attitudes, along with the blaming and shaming of patients for their health conditions, were admittedly uncomfortable for me, although not surprising.

In Haiti, the elite class is mostly represented by a mulatto, or mixed race (Mulatto, 2013), group who are usually of lighter complexions and European and Middle Eastern phenotype, due to the historical presence of the French, Spanish, Dutch, Syrian, Portuguese, and Lebanese

(Wilentz, 2013; Dubois, 2012; Zéphir, 2010). For this study, interviews were conducted with patients and providers of various socioeconomic and ethnic backgrounds, in addition to diverse phenotypical presentations, languages, and professional statuses. I am a lighter-complected Haitian American who speaks Kreyol with a strong accent, which immediately alerted participants to my "otherness" in this context. My complexion is noted because *colorism*, or the discrimination of another based on skin complexion (typically darker complexion), has been observed to be a significant issue of Latin America and the Caribbean (Sawyer & Paschel, 2007; Louis-Gates, 2011), and Haiti is not an exception, although it is less likely to be discussed among Haitians. Simply put, lighter-complexion is good, darker complexion is bad and each have implications for perceived social standing and power.

Assumptions about my background were made, discussed, and sometimes acted upon by participants during data collection. Some patients chose to share their perception of me as being "red" racially or fluent in French or English linguistically, based on my phenotype and role as a researcher from "somewhere" other than Haiti. Perceptions of me as a privileged person in this context were also sometimes demonstrated in the language choices of some participants. This was particularly evident with doctors who initiated or infused French phrases (the perceived "language of the educated") in their discussions with me, despite the fact that I only spoke Kreyol (the perceived "language of the people") with them. Patients' reluctance to discuss or identify with a socioeconomic class is also noteworthy. Conceivably, this was related to the above mentioned social dynamics of class and race in Haiti.

In attempting to understand the relationships between Haitian providers and patients, as well as Haitian providers' perceptions of patients, there may be much to learn from psychoanalytic theory. Rita Charon, a physician who has sought psychoanalytic principles to

help deepen the quality of provider-patient relationships, bridges the relationship between psychoanalysis and medicine. Charon has drawn her concept of *narrative medicine* (Charon, 2008) from psychoanalytic ideas of *transference* and *countertransference*. This concept and the utility of training health professionals to deeply engage in the stories of their patients by creating their own stories of their experiences with patients could not be explained any better than by Charon herself. *Narrative medicine* seeks to,

> …teach professionals and trainees about what patients go through, to attend to the interior of those who practice medicine, nursing, or social work, and to develop the competence to recognize, absorb, interpret, and be moved by the stories of self and other (Charon, 2008, pg. 25).

Learning the practice of narrative medicine is a skill that Charon asserts benefits the patient and the provider. The concept promotes a marrying of psychoanalytic principles, in addition to other disciplines that teach the techniques of introspection and story-telling, with medicine. She extends Freud's (1912) original notion about transference to encourage providers to allow the patient to utilize them as "vessels" for the patient's health experience.

Transference and *countertransference*, as psychoanalytic concepts assume that the relationship between patient and therapist is founded on a previously constructed relational template. The patient *transfers* her feelings about "self and other" onto the therapist and in return, the therapist experiences a feeling that is either a projection of the patient or a derivation from the therapist's own template that is evoked by the patient. The therapist's countertransference is encouraged to be examined and well-understood to be effectively utilized by the therapist in service of treating the patient (Winnicott, 1956). If left unexplored, countertransference could hamper the treatment process in that the therapist is unable to see past her own projections to help the patient identify her intrapsychic needs. The notion of

countertransference feels particularly applicable to the providers in this study, given their strong views on patients and perhaps the impact of those perceptions onto their treatment of patients.

For foreign providers, their perceptions of patients appeared to be simpler, with one describing them as "happy" and loving patients who "sing," while others made note of patients' ability to smile in spite of their circumstances, almost wanting to suggest that patients were, dare it be said, *resilient*[10]. For Barbara, it appeared especially difficult for her to say anything negative about patients (p.64 in chapter four). These split representations of patients are striking and bear to mind the defenses of *reaction formation, idealization,* and *devaluation*, which then implores the question, why would providers need to use these defense mechanisms? What is the anxiety or guilt that they defend against about?

Conceivably, foreign providers' anxiety could be attributed to unfamiliarity with the context or with the population. However, in this study it appears that the frequency of visits to Haiti was not directly linked to providers' sense of ease with the work setting and patients. Both Suzanne and Barbara indicated that they had traveled to Haiti many times before their visit during this study. Yet, John and Kadir, who had never traveled to Haiti prior to their mission trip, although they had experience with similar work in other less developed nations, appeared to offer more culturally sensitive remarks about their experience in Haiti.

English pediatrician and revered psychoanalyst Donald Woods Winnicott's ideas about hate in the countertransference (1949) might provide some insight.Winnicott (1949) entreated analysts to examine their hate of patients, maintaining that it is inevitable for therapists to have

[10] Sarcasm aside, the overuse of this term to describe Haitians in general is problematic. It is troubling because the hyperfocus of often well-intended practitioners, psychologists, journalists, etc., on "Haitian resilience" does not appear to leave room for a discussion on the reasons for the need for the resilience in the first place.

both loving and hateful feelings about patients who can be “irksome” and “burdening.” He refuted the notion that the therapist is always forgiving and practicing objectively or scientifically with his patient. He recommended that once the hate is explored within the therapist, and an adequate alliance is established, it be used to help the patient and prevent the therapist from acting out his hate onto the patient. The patient’s ability to tolerate his own hate depends on the awareness of the therapist’s hate. Further, he suggested that the integration and awareness of the therapist’s hate and love is healing for the patient, when he is able to utilize it. Applying this understanding of the potential for hate in a provider-patient relationship, it appears that practitioners in Haiti would do better by recognizing hate within themselves when servicing patients. Black Martiniquan psychiatrist (Wideman, 2008) Frantz Fanon offers an explanation for where this hate stems in his highly significant work on colonized nations, *Wretched of the Earth* (1963).

Based on his experiences as a medical student in France and time in Algeria, Fanon contributed to African and Caribbean world history an almost prophetic work, that deconstructs the psychological impact of European colonization in presently African or Black nations. Fanon (1963) explained that during colonization of the developing world, the colonists and the colonized maintained a relational constellation that he describes as envious and mistrustful. Colonists promoted a demonized image of the colonized in the compartmentalized world that colonists created, which Fanon theorizes had lasting effects on the self-image of the colonized. Even when the colonized was able to gain independence from the colonists, through violent means, the colonized perpetuated the same dividing social constructs and destructive ideas of the dominating class’s superiority and the rural class’s inferiority. This led to the creation of powerful elite classes and interethnic and intertribal discontent. The elite class viciously protects

its relationship with the colonists and maintains the same suspiciousness of the rest of the colonized that the colonists had of them. He states,

> The national bourgeoisie, which takes power at the end of the colonial regime, is an underdeveloped bourgeoisie….In an underdeveloped country, the imperative duty of an authentic national bourgeoisie is…to learn from the people, and make available to them the intellectual and technical capital it culled from its time in colonial universities….the national bourgeoisie often turns away from his heroic and positive path, which is both productive and just, and unabashedly opts for the antinational…path of the conventional bourgeoisie…. (Fanon, 1963, p. 98-99).

Fanon vehemently criticizes the elite, or the “bourgeoisie” for only being concerned with its own “intermediary” interests with the Western world, from whom the colonized bourgeoisie has learned its “antinational” habits. He purported that this intranational conflict between the bourgeoisie and the “peasantry” festers a deeply held contempt for each other. He also attributes the colonist’s “fabricated” image of the colonized to the fear and demonization of the rural population.

In *Wretched of the Earth*, Fanon also spoke to the bourgeoisie’s competition with traditional leaders, indicating that they are often whom the “rural masses” seek before the bourgeoisie. This created a barrier for the bourgeoisie’s business opportunity with the rural masses, and thus impeded opportunity with the colonists or other “Westerners.” The rural population, who remained “community-minded” and loyal to indigenous practice, is mistrustful of the bourgeoisie. Patients in this study suggest, however, while some do opt to use traditional medicine as a substitute or alternative for often unaffordable modern medical care, some patients use traditional methods as a preventive measure. Patient Martine (p.72 in chapter four) indicates that she uses herbal healing methods for stress, which could have impact on her overall health. This is likened to “self-prescribed methods” that may be commonly used in the US such as a

healthier diet, exercise, or relaxation techniques, all of which, as Martine explained about herbal medicines, may have more lasting impact than pharmaceutical drugs.

Fritz, a physician in this study whose frustration and anger towards foreign health care providers, the Haitian diaspora, and patients was almost palpable, addressed the mistrust of providers and their interventions during his interview. Fritz called Haitian professionals to end the “hypocrisy,” or the split between their stated scientific beliefs and traditional healing practices. He discussed the problem of Haitian providers who discourage patients from using traditional methods of healing while secretly observing the same practices themselves. He might have been asking for Haitian physicians to either integrate or to make a choice between their beliefs and practices. He was also asking for a return to a community-minded approach to healthcare- a *kombit* style approach, if you will.

Providers’ splitting of beliefs and practices could also be viewed as a splitting of professional and personal identities, or selves, with providers’ identification with science demarcating their superiority and distinction from the inferior “Other” who bears their projected aggression (Altman, 2010). Fanon’s work may explain the aggression, but Winnicott (1960) and Hill (2011) provide an understanding on the development of the splitting.

Winnicott believed that in infant development, the development of the child’s “true self” rests upon the balance of met ego and id needs, properly nurtured within a mother-infant relationship. An unhealthy “false self” is organized when these needs are not met adequately and the large gap between the true self and the false self impedes the true self from living freely and creatively in a social world (Winnicott, 1960). In what could have been an otherwise healthy development of a false self, which allows for the existence of a true self who employs false self moral tendencies when needed, becomes problematic for the social individual who uses the false

self to defend against ego and id impulses. Plainly, when the false self takes over, the true self can not be free and this is troubling for the individual as well as the people with whom he is in relationship. Winnicott suggests that the integration of these "selves" is best for the relational individual.

Hill (2011) adds to Winnicott's theory with the notion of a "social false self" for individuals identifying with an oppressed social group. Citing Altman's (2010) argument for a triadic therapeutic relationship consisting of the patient, the therapist, and the social contexts of each, Hill maintains that often within cross-cultural relationships emerges the need for the social false self. Individuals holding a marginalized social identity (ies) develop a social false self that serves as a self who is more assimilated and acceptable to others. The social false self, according to Hill, can be adaptive as well as maladaptive within relationships. Maladaptively, a social false self creates tension between the true self and the self that wishes to be pleasing to a cultural "other." She encourages the clinician to be sensitive to the manifestations of a social false self within a therapeutic relationship where, as Winnicott (1967) and Altman (2010) explain, exists the cultural experience. Hill also encourages the clinician to be mindful of the clinician's role in evoking the social false self.

There are applications of this idea to the provider-patient relationship of participants in this study in addition to the brief interaction between the interviewees and me. Within the provider-patient relationship, the need for a false self, or a social false self, may emerge with the practitioner who wishes to be seen as the expert or authority, especially given how valued this is in Haitian culture. For the Haitian provider who may not identify with the bourgeoisie, but with the invisible Black middle class of Haiti, as do most of the providers in this study, the tension between a true and false self may be high. Whether it be a false self, or a social false self, the

Haitian providers in this study may have been utilizing a sense of self that was not aligned with their true selves, in the service of presenting themselves as highly educated professionals identifying with a dominant classist and colorist group who also disavows the benefits of "the people's" medicine. This disavowal also raised perceptions of patients that were just as disapproving, no doubt, a common dynamic within the provider-patient relationship in Haiti and not just during this study.

There were a few examples of "true self" providers in this study. Delner, the doctor who studied in Cuba and referred to himself as the "community health doctor," could be viewed as a prime example of a provider who has utilized his "true self" creativity to integrate traditional medicine into his practice of modern medicine to respect and better meet the needs of rural patients. Suzanne, the American pediatrician from the second site who spoke of creating networks with other providers in Haiti to offer a continuity of care for patients, could also be an example of a true self manifestation. Suzanne gave what could be considered a more integrative perception of patients when she described them as "appreciative…warm…friendly," in addition to speaking on their grave health conditions when she indicated that patients were also very "sick."

More examples of true self providers include Kadir, a Pakistani American doctor who traveled to Haiti immediately after the earthquake, presented his ideas on the selective roles of foreign health care providers in Haiti, maintaining that this would help build support of skilled and available Haitian providers. Delner and Marjorie and Geraldine, Haitian nurses from Site One, requested that providers take on the responsibility of "entering" the patients' language to effectively communicate to and understand them. To quote Delner, patients have "…the right to come and explain something to you that you don't understand." Geraldine further offered that a

more “human” approach is needed in response to the many losses that patients endured after the earthquake.

The General Assembly of Healthcare Actors

Recently at a concert in New York featuring iconic Haitian musicians and historians, on stage were, as the headliner Emeline Michel put it, “the honest voices of Haiti.” During a question and answer session after the intimate concert, a non-Haitian audience member posed a question about the universality of the music. Specifically, she wondered about the music’s ability to move her in spite of the fact that she did not speak the languages of the musicians. This beautiful and thoughtful question appeared to have already been answered by Michel’s introduction of the artists as “the honest voices,” which implies that these artists address the truth in their work.

In the new conceptualization of a *kombit*, whose new definitional structure has been engendered in this chapter, there is a recommendation for an integration of participants from diverse social spheres into the working group. This was exemplified in the earthquake medical response of 2010 in Haiti. The patients and providers of this healthcare *kombit* worked collaboratively for a common purpose. In moving towards a reform of the Haitian health system, these *kombit* members, if speaking truthfully and if organized true to a collective self, hold the power to have universal impact on healthcare in Haiti.

Study Limitations and Suggestions for Future Research

There were a few limitations that were inherent to the study design, time allotted for data collection, and my bias. These limitations impacted the selection of study participants, and perhaps, as well as some participants’ response to the research questions.

In phase I, due to timing constraints to complete this phase of the study, prior to collecting data in Haiti, only two weeks were devoted to recruitment of participants for the focus group. In addition, there was not sufficient time after the focus group to organize another group interview for more participants. As such, the group interview was conducted with only two participants, without an opportunity for follow-up with participants who had initially agreed to be in the interview. It should also be noted that group interview participants were familiar with me through my travel with them on the medical mission trip after the earthquake, which is discussed in the introduction chapter. To reduce bias in the analysis of the data from this interview, the transcript of this interview was co-rated with a colleague to increase the reliability of the coding schemes that emerged from the data, although it is recognized that this does not reduce any biases that might have been inherent to the interview itself.

Due to conflicts with protecting participants and their privacy, not many foreign providers were represented in the study's second phase of data collection, resulting in a sample of only five foreign health care professionals from both phases. Also due to the timing constraints for data collection, I did not engage in a continuous collection of data as themes emerged and more information was needed. Data was collected over the course of a two-month period during the summer before I began a pre-doctoral internship in New York.

In addition, the findings from this study should be viewed as descriptive, as there was not an attempt to construct theory from the themes that emerged from the data, which is the common practice of the *Grounded Theory* tradition (Charmaz, 2006). Although the delimitations and limitations of this study impede the development of a causal or explanatory theory, the results of this study support an emerging theory about the complexity of provider-patient relationships in Haiti. Relationships between medical providers, both foreign and Haitian, and Haitian patients

reflect the hierarchical sociocultural dynamics of Haitian society, which were constructed by the nation's complex political history with other, more powerful, nations. Issues of power, as they are conflated with race and class, pervade the interactions between providers' and patients.

Future Research

Future research of provider-patient relationships in Haiti would benefit from a mixed-method study design that incorporates quantitative assessments of interpersonal relationships that directly ask about various indices of provider-patient interaction such as communication, trust and mistrust, like and dislike, and level of perceived empathy.

Due to the delimitations of the study design, patients' perspectives were difficult to obtain and not as prominent in the study results as originally sought. A future study design grounded in a community-led and more collaborative approach to gathering data, such as Community-based Participatory Research (Israel, Eng, Schulz, & Parker, 2005), might allow for better representation of patients' perspectives. In this approach, the community under study leads the effort in increasing knowledge about the community as well as identifying needs. Key informants, such as traditional healers, clergymen, and other stakeholders, would be sought for study design guided by this approach to offer more insight into the health practices and beliefs of Haitian patients.

In addition, a future study should consider examining the impact of race, ethnicity, and color on a complementary level (Green, Creswell, Shope & Clark, 2007). This means that the researcher explicitly seeks to understand the influences of race, ethnicity, and color through its sampling strategy and interviewing style.

Finally, future research with more representation of foreign health care providers is needed to better understand the perspectives and experiences of foreign-provider and patient relationships in Haiti.

***Planting a New Life*: Implications and Recommendations**

In this study, foreign providers indicated that they were not informed of various aspects of Haitian culture, like traditional healing practices and Haitian explanatory models of illness. In attempting to build a health system that can incorporate the services and skills of foreign health professionals, it is imperative that foreign professionals educate themselves on the essential values and beliefs of the culture in which they plan to deliver care.

For the Haitian health system, an integration of traditional medicine into the training and practice of Haitian health professionals is needed. One study participant's experience in Cuba was presented as an example of how this integration and respect for traditional beliefs can be beneficial to providers and patients alike.

For mental health professionals, Haitian providers may benefit from a space in which issues of identity can be sorted to more authentically serve patients. Some providers may feel a conflict embedded in a sociocultural dynamic, which results in the development of a social false self, or maybe a professional false self. Mental health practitioners can also serve on interdisciplinary health teams to teach communication skills to providers.

Conclusion: What Patient-Centered Care Means (Could Mean) in Haiti

In the Haitian health system, "patient-centered care" may not yet refer to a practice of empowering, advocating for, or directly addressing the health needs of patients (Sofaer & Firminger, 2005). Given the complex history of Haiti and Haitians, and as a result, the present ailments of a country that is often misunderstood, misrepresented, and blamed for its current

condition, the practice of patient-centered care may be predicated on one step before this. Patients may benefit first from a practitioners' ability to keep in mind and make use of his or her experience in the cultural world as it exists in the provider-patient relationship.

In a personal communication with a doctor in Haiti, the need for the presently paternalistic model of interaction with patients was discussed. The doctor felt strongly that patients would prefer a doctor who presents as the authority and the expert on the patient's health. According to this doctor, and a couple of doctors in this study, patients in Haiti want the doctor to inform them of the "right" medical choices. While it may be culturally syntonic for the provider to be the authority on health and the patients' medical condition, it behooves the provider to examine within himself his countertransference- whether it nests hate, fear, or mistrust resulting from larger social systems- to sensitively serve his patient. If the provider must come after God, then like God, providers can be authoritative- as well as authentically loving.

Researcher Reflections

In the introduction of this document, I discussed the experiences that helped to inspire, inform, and shape this dissertation study. In the process of drafting this document, I shared some of the work with close family members who expressed their sincerest interest, intrigue, and support of the study. It was an honor to have such tremendous involvement of family members in the preparing for, the thinking about, and the sustenance in completing the study over the past two years. During the arduous, yet AMAZING, course of drafting this document, I received the note below from my aunt, a very special and dear aunt whom I consider my “first mentor.” This note is included in this document because it wholly and insightfully summarizes the overall and core intent of this dissertation study: to present experiences, begin dialogue, and inspire change.

March 6, 2013, 1:12am

Cidna:

I'm not just saying this because you are my niece, BUT I was intrigued by the subject matter, enlightened by what I learned of the practices (natural and medical), instructed about the push and pull of doctor/patient and foreign/local provider relationships and at times infuriated by the misguided, racist, prejudiced and biased attitudes of providers and patients alike!!!! The findings were real and so fresh, authentic and deeply human. It was refreshing to read about the providers and their experiences and insights into the health system. Reading this excerpt caused me nostalgia and longingness to return to Haiti to help again. BUT it also gave me some hope that with this open and frank prescription of dialogue between professionals and patients, maybe, just maybe Haiti might "get and feel better" one day. Thanks for sharing Cid! And CONGRATULATIONS for a great start!

I have attached my editorial comments in a separate email.

Tats[11]

[11] “Tats” is my nickname for this aunt, which derives from the Haitian Kreyol word for aunt, *Tati*.

Appendix A. *Translation forms*

Translation Feedback Form

Birthplace: *City/Province* ____________________ *Country*____________________

Current Residence: *City*_____________________ *State*________________________________

(For Haitian natives) **How long have you lived in the US?** ______________(*months/years*)

Current Profession: ____

Which languages do you speak? (Mark an "X" next to all that apply)

____English ____Haitian Kreyol ____Spanish ____French ____Other: _________________

Please indicate your level of fluency in Haitian Kreyol in the following areas. (Fill in "X" in the appropriate boxes):

Level of Fluency*	***Speaking***	***Reading***	***Writing***
Elementary Proficiency			
Limited Working Proficiency			
Professional Working Proficiency			
Full Professional Proficiency			
Native or Bilingual Proficiency			

Please provide your feedback in the following areas for each translated text.

Form/Script	**Overall Accuracy** (poor/fair/good)	**Conceptual Accuracy** (poor/fair/good)	**Errors** (none/some/ many)	**Suggestions for Revision/Comments**
Contact Sheet				
Script for Introducing the Study				
Script for Oral Consent				

***Descriptions of Levels**

Elementary Proficiency

- can ask and answer questions on very familiar topics; within the scope of very limited language experience
- can understand simple questions and statements, allowing for slowed speech, repetition or paraphrase
- has a speaking vocabulary which is inadequate to express anything but the most elementary needs; makes frequent errors in pronunciation and grammar, but can be understood by a native speaker used to dealing with foreigners attempting to speak the language

Limited Working Proficiency

- able to satisfy routine social demands and limited work requirements
- can handle with confidence, but not with facility, most social situations including introductions and casual conversations about current events, as well as work, family, and autobiographical information
- can handle limited work requirements, needing help in handling any complications or difficulties; can get the gist of most conversations on non-technical subjects (i.e. topics which require no specialized knowledge), and has a speaking vocabulary sufficient to respond simply with some circumlocutions
- has an accent which, though often quite faulty, is intelligible
- can usually handle elementary constructions quite accurately but does not have thorough or confident control of the grammar.

Professional Working Proficiency

- able to speak the language with sufficient structural accuracy and vocabulary to participate effectively in most formal and informal conversations on practical, social, and professional topics
- can discuss particular interests and special fields of competence with reasonable ease
- has comprehension which is quite complete for a normal rate of speech
- has a general vocabulary which is broad enough that he or she rarely has to grope for a word
- has an accent which may be obviously foreign; has a good control of grammar; and whose errors virtually never interfere with understanding and rarely disturb the native speaker.

Full Professional Proficiency

- able to use the language fluently and accurately on all levels normally pertinent to professional needs
- can understand and participate in any conversations within the range of own personal and professional experience with a high degree of fluency and precision of vocabulary
- would rarely be taken for a native speaker, but can respond appropriately even in unfamiliar situations
- makes only quite rare and unpatterned errors of pronunciation and grammar
- can handle informal interpreting from and into the language.

Native Bilingual Proficiency

- has a speaking proficiency equivalent to that of an educated native speaker
- has complete fluency in the language, such that speech on all levels in fully accepted by educated native speakers in all of its features, including breadth of vocabulary and idiom, colloquialisms, and pertinent cultural references.

From the InterAgency Language Roundtable, 2011, http://www.govtilr.org/.

__Appendix B.__ Interview Schedules of Questions

Date__________________ **# of Participants___**

Phase I
Group Interview with Providers
Interview Schedule

1. Please tell me how you made the decision to volunteer in Haiti after the earthquake?

2. How did you prepare for the trip, if at all (i.e. mentally, physically, professionally)? What kind of advice/training/resources did you use to prepare?

3. Thinking back to when you decided to volunteer, what did you imagine you would be doing on a day to day basis?
    a. Tell me what you imagined a typical day would be, from the moment you would get up to when you would go to bed.

    b. In as much detail as possible, tell me about an actual typical day.

    c. Now, reflecting on what you imagined and what you actually experienced, how were these similar and different from one another?

4. Tell me about an experience or two in which you felt like a cultural "outsider."
    a. Did you consult with anyone or get guidance on how to handle the situation in the moment or afterwards?

5. Where were you delivering services prior to going to Haiti? Tell me about a typical day in that work.
    a. How did you adjust your typical manner of practice in Haiti?

    b. Briefly describe the medical setting and the patients with whom you worked. How were the patients similar or different from patients serviced in your regular practice?

6. Tell me about a time or two when you sensed that your patients' beliefs about illness and health were different from your own?

7. How would you describe the relationship that you had with patients in Haiti?

8. What are your perceptions of the quality of care that was delivered to patients after the earthquake?

9. What do you believe to be important components of the provider-patient relationship? How were these components present in your relationship with Haitian patients?

10. Describe the ideal relationship with patients. What challenges were encountered in developing the ideal provider-patient relationship with Haitian patients? What factors helped in developing the best relationship possible?

11. For the second phase of my study, I will be interviewing providers and patients in Haiti. What do you feel would be among the most important questions to ask of participants in regards to the quality of health services and provider-patient relationships in Haiti? Furthermore, what aspects of patients' experience receiving care in Haiti would you like to know more about?

Phase II
Individual Interview with Patients
Interview Schedule

Date__________________ **Participant ID #_______**

1. Describe the best experience of receiving medical care that you've ever had. Describe the worst experience that you've ever had.

2. How would you describe health care services in Haiti before the earthquake? After the earthquake?

3. How has your access to healthcare changed or stayed the same since the earthquake?

4. How satisfied are you with the overall quality of healthcare you've received in the past 2 years?

5. How has your utilization of health services changed or stayed the same since the earthquake?

6. Does anyone accompany you to your medical appointments (i.e., relative, friend, community health worker)?
    a. What is his/her role? How does he/she help you during your visit?

7. Which model of health best captures your conceptualization of physical illness?
    a. People become sick because of spiritual demons
    b. People become sick because of other physical health problems
    c. People become sick because of poor hygiene and lack of self-care
    d. People become sick because someone else who does not like them has done something
    e. Other reason____

8. Other than coming to the clinic/hospital, how else do you take care of yourself when you are ill?
    a. What other forms of medicine and healing methods do you use? How comfortable are you with discussing these other healing methods with your provider? If discussed, how does he/she respond?

9. How do you take care of yourself after a clinic visit?
    a. Do you return to the clinic for follow-up care?

10. How do you feel about the overall treatment that you've received from providers since the earthquake? In this hospital/clinic?

11. How would you describe your relationship with healthcare providers at this site?
    a. Have you received care from foreign providers? How would you describe your experience?

   b. How does your experience with foreign providers compare/differ from your experience with Haitian providers?

12. How do providers come to decisions about your healthcare (i.e. diagnosis and treatment plan)?
    a. How much input do you have?
    b. How comfortable are you with asking questions about the decisions?

13. How does the provider talk to you about your health?
    a. How would you prefer it?
    b. What language do the providers speak with you?
    c. How do you feel about the use of translators?

14. How much confidence do you have in the providers caring for you?

15. What advice would you give to medical providers in regards to your health care?

16. What is your overall perception of providers at this site?

Faz II
Endividyèl Entèvyou ak Pasyan
Kesyons

Dat___________________ ID Patisipan______________

1. Pale m ki pi bon eksperyans ou fe nan swen medikal. Pale m ki môve eksperyans ou fe nan swen medikal.

2. Konman w te jwenn sèvis santé anvan tranbleman tè a? E apre tranbleman tè a?

3. Ki chanjeman ou we nan sevis santé depi tranbleman te a? Ki sa w we ki toujou menm jan?

4. An jeneral, konman w we kalite swen medikal la ye an Ayiti nan 2 an yo ki sot pase a?

5. Konman ou we bezwen w pou sevis klinik yo chanje ou byen ret menm jan depi tranbleman te a?

6. Eske gen moun ki akonpanye-w nan randevou medikal ou (setadi, fanmi, zanmi, moun ki travay nan santé kominote?

   a. Moun sa ki mene w nan klinik la, ki jan de ed li bay ou? Konman li ede w pandan visit la?

7. Sa w panse ki koz maladi?

   a. Moun vin malad pou tet move lespri
   b. Moun vin malad pou tet lot pwoblem santé fizik
   c. Moun vin malad pou tet mank de ijyen ak bon swen
   d. Moun vin malad pou tet yon lot moun ki pa renmen yo ki fe yon bagay
   e. Lot rezon

8. Le w malad, a pa de vini nan klinik la/lopital la ki lot jan anko ou pran swen de tet ou?
   a. Konman w santi w de pale de lot remedy o ou pran avek dokte ou a? Ki sa dokte a di le ou pale de lot remed yo ou pran?

9. Konman ou pran swen de tet ou apre ou fin vizite klinik la?
   a. Eske ou retounen nan klinik la pou fe dokte a konne jan ou pote w?

10. An jeneral, konman ou santi w de tretman w ap resevwa nan men moun ki bay swen santé yo?

11. Konman relasyon w ye avek moun k ap travay nan klinik la?

12. Eske w janm resevwa swen nan men moun etranje? Pale m de eksperyans ou.
    a. Konman w ta konpare eksperyans ou ant moun etranje e Ayisyen?

13. Kijan moun yo approche w le pou pran desizyon sou swen w (setadi, dyagnostik ak tretman)?
    a. Ki sa w ka di nan desizyon yo pran a?
    b. Konman w santi w pou poze kesyon sou desizyon yo?

14. Konman moun yo pale w de santé w?
    a. Konman w ta pito l?
    b. Ki lang moun yo pale ave w?
    c. Ki jan ou santi w le moun ap fe translasyon pou ou?

15. Ki konfyans ou gen nan moun kap pran swen w yo?

16. Ki konsey ou te ka bay moun yo nan swen yap bay yo?

17. Konman w we an jeneral moun yo kap travay nan klinik sa?

Phase II
Individual Interview with Providers
Interview Schedule

Date__________________ **Participant ID #_______**

1. ***For native providers:*** How has your provision of care changed or stayed the same since the earthquake?
   For foreign providers: How has your practice of medicine changed or stayed the same since working in Haiti?

2. ***For native providers:*** How has your model of interacting with patients changed or stayed the same since the earthquake?
   For foreign providers: How has your model of interacting with patients changed or stayed the same since working in Haiti?

3. What factors do you consider in making decisions about patients diagnosis and treatment?

4. Do you involve patients in making decisions about his/her healthcare? How much?

5. Which model of healthcare interaction best captures your approach in interacting with patients?
   a. Diagnosing and treating patients with limited patient participation
   b. Provide the patient with as much information as possible about their diagnosis and treatment options and allow the patient to select his/her preference
   c. In addition to providing information, assessing the patients values and selecting the mode of intervention based on both the patient's preference and the best care

6. What do you feel is the common approach for interacting with patients practiced in Haiti?
   a. What do you feel patients prefer?

7. What is your understanding of the term "patient-centered care" or "patient-focused care?"
   a. What are your thoughts on the practice of patient-focused care in Haiti?

8. What is your understanding of traditional healing methods and beliefs about illness in Haiti?
   a. Have you ever incorporated traditional healing methods in your practice?

9. Which model of health best captures your professional conceptualization of physical illness?
   a. Medical illness derives from biological and physiological factors
   b. Medical illness derives from biological, psychological, and social factors
   c. Medical illness derives from biological, psychological, social, and spiritual factors

10. How do patients discuss their beliefs about illness and healing with you?

11. ***For foreign providers:*** Have you had any interaction with native providers? How would you describe your relationship with them?

For native providers: Have you had any interaction with foreign providers? How would you describe your relationship with them?

12. ***For foreign providers:*** Have you used translators in delivering services?
    a. What language does the translator speak with patients?
    b. What is your perception of how patients feel about the use of [French or Kreyol]?
    c. How does the use of a translator affect your interaction with the patient?

    For native providers: What language do you speak with patients?
    a. What is your perception of how patients feel about your use of [French or Kreyol]?

13. What is your overall perception of patients at this site?

Faz II
Endividyèl Entèvyou ak Moun Ki Bay Swen
Kesyons

Dat__________ ID Patisipan________

1. Pou prestataires natif natal: Konman fason ou bay swen chanje ou rete menm jan depi tranbleman tè a?

2. Pou prestataires natif natal: Konman fason ou kominike avèk pasyan yo chanje ou rete menm nan depi tranbleman tè a?

3. Ki sa ou konsidere le pou pran desizyon sou dyagnostik ak tretman pasyan?

    a. Eske w mande pasyan yo pou pran desizyon sou swen yo?

4. Ki modèl de swen ki pi byen kaptire apwòch ou avèk pasyan?

    a. Bay dyagnostik ak tretman san patisipasyon pasyan a
    b. Bay pasyan an anpil enfòmasyon sou dyagnostik ak opsyon tretman e pèmèt pasyan an chwazi

5. Ki sa w panse se apwòch ki pi an komen nan fason prestataires kominike avèk pasyan an Ayiti?

    a. Ki sa ou panse malad yo ta pito?

6. Ki sa ou konprann sou tèm "swen pasyan-konsantre?"

    a. Ki sa w panse sou pratik “swen pasyan-konsantre” an Ayiti?

7. Konman w santi de metòd tradisyonèl pou geri ak kwayans sou maladi an Ayiti?

    a. Èske w janm enkòpore metòd tradisyonèl nan pratik ou?

8. Sa w panse ki koz maladi?
    a. Moun vin malad pou tet move lespri
    b. Moun vin malad pou tet lòt pwoblèm sante fizik
    c. Moun vin malad pou tet mank de ijyèn ak bon swen
    d. Moun vin malad pou tet yon lòt moun ki pa renmen yo ki fè yon bagay
    e. Lot rezon:

9. Konman pasyan yo pale de kwayans yo sou maladi ak gerizon avè w?

10. Pou prestataires natif natal: Èske ou janm travay avek prestataires entranje?
    a. Konman ou ta dekri relasyon ou avèk yo?

11. Pou prestataires natif natal: Ki lang ou pale avèk pasyan yo?

    a. Ki sa w panse pasyan yo santi le w ap pale franse?

12. An jeneral, ki pèsepsyon w de pasyan yo nan sit sa?

Appendix C. *Demographic Questionnaires*

Date_____________ **Participant ID_______________**

Demographic Survey for Patients

Thank you for agreeing to participate in this study. All information collected on this survey is confidential and will only be used for the purposes of this research study.

1. How old are you? _____

2. What is your sex?
   a. Male b. Female

3. Birthplace____

4. Where do you currently reside? City__________________ Province___________________

5. How long have you lived at your current residence? _______________

6. How long does it take to travel from your home to the hospital? ___________(miles/minutes)

7. What languages do you speak?

Language	Read	Write
	☐	☐
	☐	☐
	☐	☐

8. What is your current occupation? __________________________________

9. How long have you been in your current occupation? _________________

10. What is the highest level of education you have completed?
    a. Primary School
    b. Secondary School
    c. Certificat
    d. Bac I
    e. Bac II
    f. University
    g. Technical/Trade School

h. Other____________________________

11. Do you have family and friends abroad?
    a. Yes b. No

12. Do you receive financial support from family or friends abroad?
    a. Not at all
    b. Rarely
    c. Occasionally
    d. Often

13. How do you pay for medical services?
    a. Out of pocket
    b. Support from family
    c. Financial assistance from the hospital/clinic
    d. Other _____________________________

14. What is the reason for your visit to the hospital today?
    a. Primary care
    b. Specialty care _______________________
    c. Other______________________________

15. How would you describe your socioeconomic class? ________________________________

Thank you for your time!

Date______________ **Participant ID#_______________**

Phase II
Demographic Survey for Health Care Providers

Thank you for agreeing to participate in this study. All information collected on this survey is completely confidential and will only be used for the purposes of this research study.

1. Age _____
2. Sex
   a. Male
   b. Female
3. Country/province of origin_______________________
4. Where do you currently reside?

   City___________________ State /Province__________________Country_________________
5. How long have you lived at your current residence? ________________
6. How do you identify racially?
   a. Black
   b. White
   c. Asian/Pacific Islander
   d. Native/Indigenous group
   e. I do not identify racially
   f. Other____
7. Do you identify ethnically? If so, please write in your ethnic identification (i.e., African American or Latino).

   ____
8. Please list in the left-hand column all of the languages that you speak. Also indicate your level of proficiency in each language.

Language	Beginning	Intermediate	Advanced	Proficient
	1	2	3	4
	1	2	3	4
	1	2	3	4
	1	2	3	4

9. What is your current profession?
    a. Physician; specialty in________________________________
    b. Nurse
    c. Prosthetist
    d. Medical Assistant
    e. Physical Therapist
    f. Other____________________________

10. How long have you been in your current profession? ______________

11. What is the highest level of education you have completed?
    a. Associate's Degree/Bac I
    b. Bachelor's Degree/Bac II
    c. Master's Degree/License
    d. Doctorate Degree/Technical or Trade School
    e. Other_____________________________

12. For foreign providers: Aside from working in Haiti, do you have any other professional international experience?
    a. No
    b. Yes, in ____ (country [ies])
    c. Please describe briefly your work in the other country (ies):

____

____

____

12a. How long have you been working in Haiti? ____________________________________

12b. Did you work in Haiti before the earthquake?
    1. No
    2. Yes, in ______________________________ (mm/dd/yyyy)
    3. Please describe briefly your work prior to the earthquake:

____

____

____

12c. Was your professional experience in Haiti organized by a particular group or agency?
    1. No
    2. Yes, the _____________________________ (name of organization)

Thank you for your time!

Appendix D. *Complete Code List*

	Focused Codes	***Initial Codes***
Attitudes	*Attitudes about Western Medicine*	adheres to meds and takes care of self doc prescribed meds are usually more effective than street meds doesn't asks questions, just takes meds has faith in the meds medication works medication adherence is important takes care of self
	Attitudes about Traditional Medicine	believes that traditional methods sometimes work discouraged from taking herbal meds docs will never encourage herbal meds doesnt believe in traditional healing methods was receiving care from healers sometimes takes herbal meds should wait for doc to prescribe herbal meds medical anthropology is needed because of patients' beliefs in traditional medicine doesn't consult with vodou priest doesnt know about mystical practices knows about vodou practices but doesn't believe in them
	Attitudes about Mental Health Professionals	psychologist helps with morale psychologist is valued by HIV patients psychologist needs to be more integrated into care not everyone likes going to the psychologist Having haitian MH prof was appreciated
Beliefs	*Illness Models*	illness is a physical problem illness is caused by germs illness is caused by God illness is caused by hate and evil-doing illness is caused by many things illness is caused by poor hygiene illness is caused by poor self-care illness is caused by sin illness is caused by stress God heals some illnesses have to be treated by God
Perceptions	*Foreign Providers Perceptions of Patients*	attitudes about pics changed because of patients' disappointment attitudes about pics changed over time patients had hope through photos patients were selfless when waiting for care Patients were grateful for services patients were likely to adhere to treatment patients were memorable Patients lost loved ones in the quake patients remained cheerful in spite of their circumstances
	Haitian Providers Perceptions of Patients	being a doctor helps him get to know countrymen belief in treatment depends on education level can't help patients when they lie deciding to include patients in their care depends on their level of education difficult patients need a psychologist to help them understand digging deep means finding common ground with patients patient care depends on ho wmuch they can understand the provider patients' belief in traditional methods is an obstacle in providing care patients come in with an expectation patients have a legal right to choose treatment patients lie to providers patients misattribute reasons for illness patients need education

		patients need long term care patients needed special attention after quake patients need to be trained and educated just like staff patients sometimes choose mysticism over medical science patients waste time seeing healers patients will go to healer before seeing docs some patients are really difficult to understand some patients believe evil-doing caused their illness some patients can understand some patients care about their health some patients don't care enough to take meds some patients don't come back for follow-up some patients dont want to understand some people believe in mysticism some people prefer coming to the hosp over trad methods some people use traditional methods after coming to the hosp Sometimes it's a waste of time explaining things to patients sometimes patients need more than medical services takes a lot of effort to correct patients' beliefs teaching fishing builds self-respect tries to understand patients to give care took too long to get care Teach Haitians to fish have to correct patients beliefs have to dig deep to understand patients problems have to explain to patients the cause of their illness have to give patients good care have to make choices for patients who don't understand HIV patients have rights and need to be better supported in society HIV patients need support in other ways to live comfortably in society illiteracy affects patients ability to explain symptoms In Haiti, people attribute illness to evil-doing from others not every patient understands more explanation needed to patients of lower levels of education
	Perceptions of Foreign Providers	Foreign groups should focus on prevention Foreign providers are only needed for specialty care foreign providers come give specialty services at hospital foreign providers dont make a difference in providing long term care Foreign providers work is a start to care foreigners give better care experience with foreign providers not interested in receiving services from foreigners
	Perceptions about Haitian Providers	feels mutual respect from staff feels safe with staff feels staff works collaboratively feels supported by doctor feels supported by staff Haitian colleagues were also in need Haitian providers can help more than foreign ones Haitian staff lived in similar conditions as patients Haitians should be selective about how they involve foriegn groups Haitian volunteers necessary Haitians are capable Haitian staff protected resources staff respects privacy staff takes care of him staff upbeat and professional in spite of circumstances the doctor cares the staff comes after God trusts doctor to make decisions about health trusts staff wants doctors to give better care

		wants providers not to be discouraged when patients dont comply wants services to stay the same staff is available at all times for patients providers don't judge providers are respectful and collaborative at this site more providers in city to help with cholera have to have full confidence in providers brings food from garden as gift to staff Shock about Haitian staff being in need
	Perceptions of Health System	better governance can improve healthcare system corruption is to blame for health problems Haiti needs sustainable care medical training in Haiti is good not all sites are the same putting a bandaid on greater health problems sometimes the aid isn't helpful need to think about moving forward in health care political instability and corruption are to blame for patients issues with health
	Perceptions of Health Services Since Quake	Change in Services changes in access to food and meds after quake caused HIV patient symptoms cholera brought in more staff to give care didn't pay for services after quake health services stayed the same more care available since quake no protocol for responding to quake quake affected patients ability to keep appointments services in Haiti are good
	Perceptions of Haiti	Haiti is not in the 21st century haiti needs institutions built people leave because there is no peace
	Perceptions of Security in Haiti	concerned about security Not as dangerous as reported security hype may have deterred other people for volunteering to help US media hyped security concerns
Relationships	*Communication between providers and Patients*	communication problems doesn't ask questions doesn't tell staff about other treatments explained quake to patients feels comfortable asking providers questions about care has questions about his illness is waiting to ask provider questions it's a luxury to be able to speak to patients about pathophysiology language prep medical anthropology is needed to better understand patients (language) need little vocabulary to communicate patients found ways to communicate used an interpreter was able to talk prevention with some spoke to patients about preventive strategies people were receptive to prevention information
	Relationship with providers	good relationship with staff frustrated by attitudes change in quality of connection follows orders frustrated when patients don't make the right choices interaction style knows patients well mysticism and poor hygiene makes the providers job harder no time to know countrymen when studying to be a doctor

		numbing numbing helps to do the work practices paternalistic interaction style with patients that dont understand practices patient centered care providers have become more human since the quake providers have to make decisions when patients don't understand the kind of care provider gives depends on the patient too many patients to establish a relationship
	Providers Interaction Style	considers patients history in treatment and diagnosis conversational style with patients
	Foreign Providers' Experience	became emotionally overwhelmed brought closer to the experience when there didn't feel like a cultural outsider Delivered multiple forms of care diagnosis and treatment didn't have time to discuss patients' beliefs could understand language a little couldn't help everyone Experienced Felt capable of helping Felt effort was futile felt impelled to give to patients felt it necessary to organize on the local level Felt like one of the Haitians felt more freedom working in Haiti Felt obligated to help first step in delivery care is organizing care space easier for clinicians to take pics because of relationships with patients encouraged patients to keep up with care after the quake encourages patients to follow care enjoyed more time with patients because less paperwork enjoyed working with patients groups don't coordinate or give money to gvt because they fear corruption had to stay within realm of work Haitian people resilience was inspiring less bureaucratic work in Haiti maintained relationship with colleagues after mission many groups went on feel good missions same clinical goals same practice, better equipment saw great amounts of patients some moments deserved a pic specialists make more impact Touched by selflessness of patients tried to have fun with patients wanted to be busy wanted to put medical training to use was able to refer to other specialists in team was personally affected by patients was relieved to have power and other basic needs was trained to work with few resources wasn't sure would be able to work effectively kept pictures of memorable and inspiring cases people had a lot of needs future docs need to learn how to work without many resources felt discouraged by natives to do work local providers are needed for long-term care patients felt like objects when being photopgraphed hypervigilance

Experiences	*Ways of Securing Medicine*	also buy meds on the street goes down mountain to get meds gets help from staff with filling prescriptions hospital helps with getting meds sometimes hard to find meds
	Preparation for Mission Trips	afraid of losing materials in transport consulted with professional who had traveled to haiti before emotional prep had to prepare materials for trip had to prepare professionally for trip had to be concerned about personal needs had to do homework to prepare for trip had to get materials that were transportable personal prep performance anxiety was prepared for the worst was told to receive care only from one provider trusted advice of those who had traveled before team coordination before trip protected himself from illness prepared to treat specific illnesses planning needed to consider getting the most out of the trip Necessary to have Haitian volunteers too lack of coordination wastes resources can only give what they can
	Earthquake	Didn't provide services before the quake lost during the quake no cholera before earthquake people could not believe in the quake people were panicked after the quake providers weren't sure how to help patients after the quake quake was unexpected services were good before quake wasn't injured during the quake weren't used to earthquakes Victims were not saved by God Victims got more attention than other patients One helping person attracts other helpers Care was limited providers generally prioritized victims over other patients
	Positive Experiences with Care	always has good experience at this site good experience was when staff gave her money good experience with care good health care experience is when meds are given happy with services at this site hospital saved wife's life is healthier because of care at site satisfied with care hospital is affiliated with US hospital patients who complain about staff deserved their poor treatment patients who didn't pay ruined it for other patients
	Negative Experiences with Care	bad experiences at other hospitals not satisfied with care problem with site has to get to site early to receive care
	Haitian Providers Experience	chose to be at this hospital for the experience became staff through activism as patient was raised differently from patients works at the site and receives services
	Utilization of Services	always comes to this site for care believes in consulting with the physician

		goes to hospital for more serious conditions experience with foreign providers food and transportation needs impede access to care potential for mistreatment when pts dont consult with doc
	Providers Support of Patients	advocating for rights of HIV patients hospital helps with getting meds Nurses advocate for patients to receive nutritional support from hospital receives meds and food at this site staff helps patients adhere to meds support groups for HIV patients watches educational videos in waiting area hospital educates on good hygiene hospital holds educational support groups for patients used to help patients traditionally
	Paying for Services	cant afford services doesn't come when can't afford services dont have to pay for foreign services had to pay for card to receive services have to pay for foreign care have to pay for services some hospitals don't give good care to patients without money some hospitals give free services patients can't always afford meds people sell cards to skip ahead of line staff helps with paying for services
	Mission Team Dynamics	debriefing with teammates was helpful evening debriefing helpful in many ways evening debriefing was relaxing and joyful good relationship with staff evenings were a chance to interact with colleagues team convened in the evening to debrief was happy to be among familiar and trusted people

Appendix E. Sample Segment of Coded Interview Transcript

Interview with Paula, Nurse, Site Two

Cidna: Ok. How do you discuss that with the patients? How do they discuss that with you?

Paula: It actually, it just depends on the person. What we talk about, I explain to them that the medication is only going to last so long so what then, I wait for them to bring things up, and discuss whatever they're comfortable discussing with me. [Allows patients to bring up their own topics of discussion; talks about whatever patients are comfortable discussing]

Cidna: Ok. It's interesting. How do patients talk about their traditional methods of healing or traditional beliefs about illness?

Paula: Ah! I've heard a lot about here, like voodoo, and witchcraft but it seems like most of the people that are coming in for medical attention, if they're coming in to see a doctor, they are not believing in the witchcraft, otherwise they would go see a voodoo doctor I guess you would say. So, a lot of them are open to all that spirituality, and healing that's greater than what we can do here. [Heard a lot about voodoo; patients don't believe in voodoo if they come to doctor; values spirituality]

Cidna: Do you ever incorporate traditional healing methods in your practice?

Paula: As far as like prayer?

Cidna: Oun houm.

Paula: Yes. If somebody wants to pray, then I'll pray with them. [Prays with patients]

Cidna: Ok! What are your thoughts on the practice of Haitian focused care in Haiti?

Paula: Ah! You know basic needs are what we're looking at here. We don't really see too many people that are coming in extremely ill, but just the basic needs of food and water and, you know, just bathing, and simple things that we take for granted back in the United States are what they need here and it makes so much of a difference. [Patients need basic things]

Cidna: Ah! What model of health best captures your professional conceptualization of physical illness? So medical illness comes from biological and physiological factors? Medical illness comes from biological, psychological and social factors? Or medical ill-ness comes from biological, psychological, social, and spiritual factors?

Paula: All. The last one; everything ties in together.

Cidna: Ok. Could you say more about that?

Paula: I just think everybody is mind, body, spirit; so you can't fix one thing without fixing all three. They are all tied together. [Believes in biopsychosocial model of illness]

Appendix F. *Quotes with Orignal Kreyol Text and English Translation*

Page	Interviewee	Kreyol Text	Translation
50	Fritz	M' pa wè poukisa. Pa egzanp, kisa expates, nou gen expates infirmières, poukisa nou gen expates gestionnaires de stock, poukisa nou gen expates médecin généraliste ? Nou pa manke bagay konsa an Ayiti. Gen anpil infirmières ki pap travay, gen anpil medsen ki bezwen travay. Nou pa bezwen expates sa yo. Nou pa bezwen des expates incompetents tou. Gen anpil ladan yo, le plus souvent, yo trè, trè enkonpetan. M' gen enpresyon, se yon triyaj spesyal yo fè pou yo voye enkonpetan an Ayiti. Se yon pwoblèm li ye. Eeeee, m' panse que nou bezwen des expates ki vrè, vrèman pwofesyonèl ke nou pa genyen. Nou pa bezwen des expates jinekològ, nou pa manke jinekològ. Men par contre, nou ta renmen des expates ki se spesyalis an cardioloji, an neurologie, des bagay ke nou konnen nou pa genyen, e que n'ap ka eksplwate. Men ba nou nenpòt ti personnel, soi disant infirmier. Des moun ki echwe nan peyi yo. La se pa, se pa, nou pa bezwen yo, yo pa bezwen vini.	*I don't see why. For example, what the expatriates, we have expatriates who are nurses, why we have expatriates of inventory management, why we have expatriates of general medicine? We are not lacking those in Haiti. Ther are a lot of nurses who aren't working, there are a lot of doctors that need work. We don't need those expatriates. And we don't need incompetent expatriates either. There are a lot of them, most of the time, they are very, very incompetent. I have the impression, that this is a special selection they made to send incompetent people to Haiti. It is a problem. Eee, huuuh, I think that we need expatriates that are really, really professionals that we lack. We don't need expatriates of gynecology, we don't lack gynocologists. But in contrary, we would like the expatriates who specialize in cardiology, neurology, the things that we know we don't have, and we could take advantage of. But giving us these low level staff, so called nursing staff, people who have failed in their country… at this point it is not even that we don't need them, they [just] don't need to come.*
51	Fritz	Se parce que, collectivement, nou pa pran otorite nou an men…. Epi vrè pwoblèm nan tou, c'est que, kou sa pase, ayisyen kòmanse sispann ayisyen. C'est là le problèm an Ayiti…. Sa vle di gen yon santiman.	*It is because, collectively, we don't take our authority by the hand…. And the real problem is, that is, as soon as this happens, Haitians stop being Haitian. This is where the*

		Ou gen enpresyon ke moun yo plus anvi yon lòt moun ke Ayiti. Yo plus anvi, yo plus anvi kite Ayiti menm…. Yo kòmanse pa renmen Ayiti ankò. Petèt, petèt se lè yo laba, yo pran pòz yo renmen Ayiti…. M' panse ke, sinon, m' panse que t'ap gen yon sursaut, yon réveil, t'ap gen yon révolte menm. Depi yo ka viv laba. Dayè yo gen Etazini ak Kanada k'ap absorbe yo, y'ap kite sa. Y'akouche laba, yo fè pitit laba. Tout moun santi yo byen….	*problem is in Haiti. That means that there is this feeling, you get this impression that the people desire other people than Haiti. They desire, they desire to leave Haiti even… They start not to like Haiti anymore. Maybe, maybe it's when they are abroad, they pretend to like Haiti…I believe that, if this weren't the case, I believe that there would be a uprising, an awakening, there might even be a revolt. As long as they can live abroad, well they have the US and Cananda absorbing them, they'll forget it. They give birth abroad, they have kids abroad. Everyone feels they are well….*
51	Geraldine	FV2: Non.Oh wi! m te travay avèk yon prestatè etranje? Se te yon Brézilyen; eh! M te fè yon move eksperyans avèk li paske lè sa-a se nan Sante Piblik mwen te ye, yo te voye l yon kote ki te "Bèrluet" dan le Nòrdwès. Òr lè ke Sante Piblik te al plase m la, lè ke m rive, òr w konnen yon sereng pa supoze sèrvi pou de (2) pèrsòn. Òr "à mon grand étonnement [m byen sezi]" lè m te rive sou tèren sa-a, m te jwenn blan Brézilyen sa-a ki te konn ap sèrvi avèk yon sereng fè operasyon, san asepsi, ou konprann. Li te rele doktèr Jean. Pèrsonèlman m te ekri Sante Piblik; Sante Piblik te vini, yo te retire l.	*Oh Yes! I worked with a foreign provider. He was a Brazilian; and I had a bad experience with him because at that time it was in public health that I was in. They had sent him to this area, Berluet, in the northwest….now you know that a syringe is not supposed to be used on two people. To my great surprise, when I arrived on the grounds, I found this Brazilian who was using this syringe for an operation, without "asepsi," you understand?...I personally wrote to Public Health; Public Health came and removed him.*
53	Chantale	R : Hmmm! Non, ou jwenn plis swen kay blan yo, ou jwenn plis swen. Tankou…tankou mwen menm k'ap plede malad avèk maladi tansyon sa la, tankou malad…eee..lopital medsen san fwontyè a sim pa gen kòb mwen al la y' ap fè tout bagay pou mwen. Vini pou opere san ou goud y'ap banm	*Hmmm! …You get more care from the foreigners, you get more care. Like…like me who keeps getting sick with this hypertension, …the hospital of Doctors without Borders, if I don't have money, when I go there, they do everything for*

		medikaman, fè sonografi, tout bagay san you goud, san ou goud,men ayisyen yo menm fòw gen kòb, fòw gen kòb pou bay.	*me. I go for an operation without paying a dime. They'll give me medications, they'll do sonograms, everything without paying a dime, without a dime, but the Haitian, for them you have to give money, you have to give money.*
56	Marie Solange	Pou yo plus santre yo, konsèy se : plus santre yo sou sa yap fè ya. Pa dekouraje kèlkeswa, yo kapab jwenn dè pwoblèm, dè difikilte paske se tout enstitusyon ki ka gen yon ti pwoblèm, men fòk yo menm tou yo pran sa an men. Fòk yo pa gade sa, fòk yo pa dekouraje ak pasyan paske nan sans sa yo vrèman … kòmanm ta di, defwa yo konn koze kèk ti pwoblèm, lè moun nan pa vin nan randevoul, ou fè you ekzamen pou li ou paka jwenn li sa konn koze you pwoblèm, nan sans sa, pou yo pa dekouraje etou pou Bondye kapab prete yo plis vi pou yo kapab kontinye banou swen, jouskaske nou pa kapab.	*… the advice is, for them to be more centered on what they are doing. To not be discouraged no matter what. They might find problems, difficulties, because all institutions may have a little problem, but they have to take that by the hand. They can't pay attention to that, they can't be discouraged with patients, because in this way they are very…how do you say, sometimes, they cause a little problem. When the person doesn't come to their appointment, and you do an exam for them and you can't find them, in this sense, for them not to be discouraged. In addition, for God to grant that more life so they can continue to give care…*
56	Chantale	Konsèy m'ta ba yo ki nan lòt lopital yo, pou yo bay moun yo bon swen tankou lè moun yo malad yo vini lopital epi pou yo ba yo bon swen pou yo pa kite yo mouri paske gen anpil lè moun nan malad la li vin lopital la yo kite moun lan yap griyen dan yo bay blag antre yo menm, kite moun nan pou yo mouri epi moun nan malad poul mouri yo pa menm wèl menm epi yo gen dwa menm bal randevou…sil vini ta menm yo gendwa bal randevou tounen demen si dye vle epi moun nan pa byen ditou l' bezwen wè doktè kounya yo pa plis pran swen moun nan vre kounya m' ta ba yo konsèy pou yo	*The advice that I would give them at the hospitals, for them to give good care. Like, when the patients come to the hospital and for them to give good care, for them not let them die, because a lot of [cases] when patients come to the hospital, they leave the person. They laugh, they tell jokes among them, they leave the person out to die. And the person is sick to death and they don't even see him.…I would give them advice to take care of patients.… If the person were*

		pran swen moun malad yo lè yo malad yo vin lopital pou yo pran swen moun nan paske si moun nan te byen, sil te byen li te santil pat malad li tap chita lakay li se paskel santil pa byen ki fèl vin lopital, map mande yo lè moun yo vin lopital pou yo ba yo bon swen ba yo bon sèvis.	*well…if he didn't feel that he were sick, he would have sat home. It is because he does not feel well that he came to the hospital. I'm asking them when people come to the hospital for them to give good care, give them good service.*
56	Francoise	FV2: Ebyen ki konsèy m te ka ba yo? Mwen menm lè m ap priye Bondye m toujou priye Bondye, pou l ba yo entèlijans, pou l ba yo espri de bon konprann pou yo konprann sa yap fè a epi pou Bondye beni yo pou l ba yo anpil pasyans lè yon pasyan vin kote yo pou yo kapab konprann kòman ke pou yo sèvi avè l, pou yo pran pasyans avèk li. Se sak fè m toujou priye Bondye pou yo, pase gen de maladi ki vin kote w si w pa gen pasyans ou pap ka sipòte l, ou pap ka sipòte l, pou yon moun pou w rive nan kad sa-a fòk ou gen pasyans,m pa konnen se sa.	*Well, what advice could I give them? Me, when I'm praying to God, I always ask God to give them intelligence, to give them the spirit of understanding for them to understand what they are doing. And for God to bless them, for Him to give them a lot of patience when a patient comes to them, for them to be able to understand how to handle them, for them to have patience with them. That's why I always pray to God for them, because there are a lot of patients who come to them [and]if they don't have patience, they won't be able to deal with them...*
56	Hugh	MV1: Sa m ta swete m ta swete pou medsen an pa nan pati pri kèlke swa moun nan, ki vin devan l fò l pran swen l pase se yon èt imen l ye, kèlke swa nivo l, ou konprann kèlke swa m ta swete, kèlke swa moun ki devan l lan li plase pou sa pase li te ale, non sèlman se kòm si se yon sèlman l fè pou l sèvi kretyen parèy li, m ta swete, kèlke swa moun ki vini, depi pasyan an vin pou sa se wòl, li se travay li, si l pa kapab ke l refere l a yon lòt medsen, men si l ka pran swen moun nan ke l swaye l.	*I would wish that the doctors aren't playing favorites with no matter who comes before them. They have to take care of them, because they are human beings, no matter what level, you understand…as long as the patient comes for [care], it is his job. It is his job, if he can't, he should refer him to another doctor, but if he can take care of him, he should take care of him.*
57	Benny	Men la reyalite aussi, c'est que pasyant yo tou, nan formation yo, yo pa egzije twòp, twòp, twòp eksplikasyon nan, nan mòd de tretman yo. Parce que, poukisa m' di sa, yo gen yon dikton senp. A partir de dikton an, w'ap wè	*…you'll see that the patient doesn't ask for much. They say, that after God, is the doctor. Ok! So that means that, the doctor, you can do everything, you are the one who decides if*

		que pasyant yo pa egzijan anpil. Yo di w' aprè BonDieu, se docteur. Ok ! Cela veut dire, docteur, ou ka fè tout bagay, se ou k' pou deside tout sa w' fè bon. Cela veut dire, se yon forme de soumission. Sa vle di ke, m' pa egzije, aprè BonDieu, se docteur.	*what you are doing is good. That means, that it is a form of submission. That means, 'I won't insist, after God is the doctor.'*
60	Regine	Jeneralman, gen pluzyè pasyan, pluzyè pasyan an Ayiti, Sa pral depann de [Male voices in the background] edikasyon moun lan wap pale an. Paske gen moun ou ka fè tout tan-an wap pale de sal ye an, li pap jamm konprann li, donk li revni a ou memm pou w pran yon desizyon pou w di "men kòman, men kòman, men kòman"; e mèm dè fwa ou pran yon desizyon pou moun lan, ou dil men kòman, men kòman, ou pale ak moun lan, ou wè li, li pa tèlman, ou pa tèlman, ou pa, ou prèske lave menn w siye atè paske sak ta nesesè, maten an nou tap pale de sa, fòk ta gen yon antwopoloji medikal, paske gen anpil tèrm moun yo ap utilize, oumemm ou pa konn tèrm yo, se chèche wap chèche joje pou wè èske ki tèrm, sa sa-a vle di; donk antwopoloji medikal-lan fòk yo ta fèl	*Generally, there are many patients, many patients in Haiti. This will depend on the education level of the person you are referring to because there are some people with whom you can spend the whole time talking about what it is, he will never understand it. Therefore it relies on you to make a decision and say "here is how, here is how, here is how;" and even sometimes you take a decision for the person in saying "here is how" and you realize that he doesn't get it. It's like you wash your hands and you put it back in the dirt, because what was important, this morning we were talking about this, there should be medical anthropology, because there a lot of terms that people are using, you yourself you don't know the terms. You're trying to figure out what these terms mean.*
61	Fritz	…m' panse, gen yon degradasyon ki fèt nan comportement pasyan yo, nan comportement paran malad yo. Autrefois, yo te plus respekte medsen an yo, yo plus respekte infirmières yo. Men kounya, moun yo agressifs, moun pa respekte moun. Yo vin dangereux. M' panse se yon situation ki difisil kounya, eeee, m' pa ka felisite pasyan yo ankò, ni paran yo ankò. Peut-être fò m'eseye wè tou kisa ki fè yo sa, men gen yon colère collective, gen yon	*…I think there is a decline in the way patients behave, in the behavior of the patients' parents. Once, they respected the doctors more, the nurses more. But now, they are aggressive, people don't respect people. They have become dangerous. I think that it is a situation that is difficult now, and, I can't commend the patients anymore, neither the*

		animosité, gen yon frustration nan sosyete a, ki fè ke, lè yon moun prezante l' nan yon institution, Surtout institution publique, li plus, li gen yon raj, li gen yon. Li tankou yon moun ki bezwen devèse l' sou public lan, sou medsen yo, sou personnel lan. Pasyan yo pa saj ankò, yo pa pasyan ankò.	*parents anymore. Maybe I have to try to see all of what has made them that way, but there is a collective anger, there is an animosity, there is a frustration in the society, that makes it that, when a person presents in an institution, especially a public institution, he/she is more, he/she has this rage, he/she has this…he/she is like a person who needs to unleash himself onto the public, onto the doctors, onto the staff. The patients are not calm anymore, they are not patient anymore.*
62	Annaise	Men an jeneral on voit que se sont des gens, moun ki à la recherche d'un mieux être (espresyon fransè), de yon swen ke yo tap chache oke, pafwa genyen konn sot tout kote yo vini, yo konn sot jus lavil monte vin la-a, paske yo di la petèt moun yo jwenn yon solusyon, petèt le yo kapab jwenn nou bayo yon bagay. Men ofon de sa, se de moun qui cherche, ki à la recherche de ,pafwa ki pa reponn a atant yo, kip a reponn a sa ke yo te expect la, men se sal.	*… people who are in search of a better being… Sometimes, there are some who come from everywhere, they sometimes come from all the way downtown to come up here, because they say here perhaps, people will find a solution, perhaps when they can find us to give them something.*
62	Benny	Ah non ! An Ayiti, tout maladi gen yon apwòch malefik d'abord. Ok, cela veut dire pasyant lan pap aksepte ke l' malad, si l' malad, gen yon rezon. Epi li chache yon rezon. Le plus souvent, rezon an se yon akizasyon ke l' fè, jan w' di nan dènye pwen an, nan sans se yon moun ki pa renmen l' ki fè l' sa. Sa se yon apwòch tradisyonèl. Se konsa ayisyen an panse l' d'abord. Men sa ke m' vle di, nan yon certain milieu, nou pa panse konsa, nan yon certain milieu, nou pa panse konsa. Nan milieu, euh nan milieu kote moun yo plus ou moins formés.	*Oh no! In Haiti, every illness has an approach "malefic" first. Ok, by this I mean, the patient will not accept that he is sick, if he is sick, there is a reason. And he will find the reason. Most times, the reason is an accusation that he is making…in the sense that it is someone who does not like him who did this to him. It is the traditiona; approach. This is how the Haitian thinks first. But what I can say, is that in certain spaces, we don't think like that…in the space where the person is more or less*

			educated.
63	Fritz	Gen yon ipokrizi ladan l' nan sans sa, yon gwo ipokrizi. Se yon efè esklavaj la, se efè mawonaj la, ou toujou ap kache sa ke w'ap fè. Men se yon pratik, medsin tradisyonèl la, se yon pratik, nou tout nou pratike, nou fè, nou renmen. Menm lè ke nou pa eksplwate l', nou pa pale de li twòp, men anba, anba, tout ayisyen bwè ti te yo. Tout medsen, kit sa l' te ye a, li kwè nan ti medsin tradisyonèl li.	*There is a hypocrisy in this in this sense, a big hypocrisy. It is an effect of slavery, it is an effect of the marooning, you are always hiding what you are doing. But it is a practice that we all practice…even when we are not exploiting it, we don't speak of it too much, but on the low, low, every Haitian drinks his little [cup of] tea. Every doctor, no matter who he is, he believes in his little traditional medicine.*
64	Delner	Yo enkòpore l. Gen kote yo aprann ou pou si w ap fè siwo avèk asosi oubyen avèk ekaliptis, li doze. Yo rele l "MNT", medsin natirèl tradisyonèl e se yon kou nòmal, tankou wap jwenn andann l fizyoterapi, ou gen dwa jwenn dalasioterapi, ou gen dwa jwenn aponkonti, donk se yon kou nòmal nan medsin lan. Donk wap pale de anatomi, medsin natirèl tradisyonèl la, li se yon kou tou. Men an Ayiti nou fè l de manyèr woutinyè, kòm si se pa la syans, lekòl de medsin ki fè l. Donk gen de fòt tandans a itilize medsin tradisyonèl an Ayiti. Okontrè ou pap jwenn gen de nan eksperyans ma p fè se sak fè m renmen kote ma p travay, m renmen travay avèk moun ki pi bay yo m santi m vo kèlke choz lè m wè m ka ede yon moun ki pa kapab. Li konn rive yon fanm ansent nan milye sa-a, olye pou l chache wout lopital, li plis kwè nan yon matwòn; ou konn sak vle di yon matwòn?"	*They integrated it. There was a part when they taught you …[how to] dosage. They call it "MNT," natural traditional medicine and it is a regular course, like you'll learn about physical therapy, hydrotherapy, you can learn acupuncture, so it is a regular course in the medical training.*
64	Geraldine	Non, non, m ba jamm dekouraje yo nan fèy, nan medsinn tradisyonèl. Sa depann de sa ke malad lan di m li genyen an; men si se yon bagay ke mwen pa gen okenn eksplikasyon de li, m pap ankouraje l; map di: "Ah! Dezole, mwen pa konn anyen de li".	*No, no, I never discourage them in using herbs, in traditional medicine. This depends on what the patient tells me he has; but if it is something that I do not have any explanation for, I won't*

			encourage him; I'll say, 'Ah! I'm sorry, I don't know anything about it.'
65	Benny	Sa-a vrèman, vrèman se pi gwo pwoblèm ke nap travèse, paske mwen memm pèrsonèlman ki pat etudye nan peyi-a, m gen dè, m gen yon lòt konsep-syon de peyi-ya; paske la ba, kant kelkun te malad, lale a lopital, men an Ayiti se totalman diferan; si moun lan malad, premye sa l pral fè li pral ka yon vodou temple, ka youn oungan; donk de la etan, si oungan pa ka fè anyen pou li, se lè sa-a lap vini e se la ankò se le nivèl edukasyonèl la ap jwe, paske plus moun lan fòrme wap jwenn sa mwens lakay li; lap kwè nan vodou temple la tou wi, men lap kwè nan chemen medikal la tou. Men moun ki pa fòrme a, kap viv dan lè mòrn, dan lè montay, sa je te garantis se trètman fèy li ou vodou temple li. Li pap vini, dayeur, tu vas voir que la personne a 50 ans, 60 ans, li di w doktè se premye fwa li vinn lopital, vu ke li toujou konnen, li gen tèt fè mal lan, lap pran vetivèr, li gen gripp lan la, lap pran fèy langichat, li gen fièv lan la-a, lap pran asosi, donk avè sa, li pap desann vinn lopital, surtou jan peyi ya ye an, sant ospitalye yo pa ale jwenn yo. Se yok pou vinn jwenn lopital, lopital pa ale jwenn yo; donk gan dè distans moun lan ap soti, li pap vini, li pap vini. Donk li prefere rete avèk medikaman tradisyonèl li ya.	*This is really, really the biggest problem that we are facing…you will see that the 50 year-old, 60 year-old, he'll say, "doctor this is the first time I've come to the hospital," you'll see that he always knew, he had the headache, he was taking "vetiver," he has a cold, he's taking "langichat" herbs, he has a fever, he's taking "asosi." So with that, he's not coming down to the hospital, especially with the way the country is, hospital centers don't go find him. They have to come to the hospital, hospitals don't go to them. So there is a distance that the person is coming from, he won't come, he won't come. So he prefers to stay with his traditional medicines.*
65	Nicole	Nou konn… Li te konn difisil pou retire anpil tabou, anpil tabou, e e e e, nan tèt yo konsa…. Donk yo rete nan fè sa yo konnen. Epi lè yo vin lopital la, yo vini two ta	*It is very hard to remove a lot of taboo, a lot of taboo, from their minds. So they stay practicing what they know. And when they come to the hospital, they come too late.*
66	Francoise	Maladi pafwa sa konn sòti nan mank lijyèn, sa konn sòti ladan l tou, pafwa tou sa konn sòti nan mank okipasyon, pase si w ap soufri grangou sa ap pote	*Illness sometimes comes from a lack of hygiene…sometimes all of this comes from a lack of self-care, because if you are*

		w malad e sitou pou sa k rele gaz la, se sa yo rele w gen yon feblès kap pote w nan tèt ou l ap pote w nan je w. Pase lè w nan okipasyon ak lè w pa nan okipasyon se pa menm bagay lè sa tou li ka enpe bay maladi men, lè w manke okipasyon li rale maladi a, magre fò w malad wi fò w soufri paske Jezi Kris li menm li te soufri, men, kondi la bib la di w Jezi ki te bwa vèt li te jwenn fason li te soufri malgre se pat anyen li te fè, men kòz pou nou menm pou peche nou yo, li te arive soufri; ebyen e nou menm ki bwa sèch. Bon fòk nou soufri, fòk nou soufri. Alò gen de maladi ou genyen pa sòti tou pa Dye pase fòk ou soufri, gen de maladi Bondye pa konnen l non se pechè k fè w sa. Gen de maladi se maladi natirèl ki fè w ap soufri, ou wè sa se maladi natirèl, pase chak moun ki la a ou te mèt wè moun nan gen lajan, moun nan pa gen lajan li gen yon soufrans kanmèm, fòk lipase pa soufrans e pou w mouri se nan yon soufrans pou w pase. M pa konnen; chak tan w gade ou wè divès kalite maladi, e pa sèlman nan le mond men patou nan peyi a, pase peche nou yo koz maladi antre sou nou tou, paske nou peche anpil	*suffering from hunger, that will make you sick. And especially for, what they call "gas," that is what they call having a weakness that will affect you mentally and visually.…when you lack self-care it draws on sickness, even though you have to be sick, you have to suffer, because Jesus Christ himself suffered.…*
66	Marie Jocelyn	Bon, lèm dil sa , li pa pran sa grav, paskel konnen ke nou menm ayisyèn , nou kwè nan sa k' rele fèy la anpil, lorsque nou malad, nou plis kwè d'abord anvan nou kouri chache doktè ou chache al nan pye bwa ki kote nap jwenn you solisyon.	*Well, when I tell him this, he doesn't take it seriously, because he knows that we Haitians, we believe in what is called the herbs a lot. So when we are sick, we believe more [in this] first. Before we run to find a doctor, [we] go to the tree where we will find a solution.*
66	Rose	Bon lò m santi m pa bon, m wè m pa gen kòb pou m vin lopital mwen pran te, fèy mwen bouyi, mwen bouyi dlo a epi avèk yon ti sik, yon ti sèl, lè fini m vide l nan yon gode m lave fèy la m met ladan l m toufe l te sa a m pran l,	*Well, when I don't feel well, and I don't have money to come to the hospital I drink tea, I boil herbs, I boil water and with a little sugar, a little salt, when I'm done I pour it in a cup,*

		epi m poze jiskaske m vire pou m gen mwayen m vin lopital	*wash the leaves, put it in there, steep the tea, I take it, and I rest until I have the means to go to the hospital.*
66	Rose	Wi, wi.Yo di w pa bouyi fèy, pa bagay, pa sesi, yo di yon pil bagay mwen m pa konn entèrese de sa. Yo pa kwè ladan.	*Yes, yes. They tell us not to boil herbs, don't do this, because, they say a lot of stuff that I'm not interested in. They don't believe in it.*
67	Martine	A nou an pi dire. Pa doktè an pi vit. Pa yo a pi vit, pa nou an pi dire, remèd doktè a ba ou a, lal pi vit sa nou fè pou kò nou an li pi dire.	*…The medicine the doctor gives works faster. What we make for ourselves lasts longer.*
67	Nickson	Ok Ok wi men w ap wèl li trè diferan deuxiement aussi parce-que li trè ekstreman important parce-que projè sa yo tou ki okipe de SIDA a ok yo resevwa spesyal finansman finance, sot they take special effort for patient yo pran beaucoup il y more more fund to take care of the patient ok more services are free, the medication are free it's different for the other people for other patient,you have to pay , you have to buy medication.	*But, you'll see that it is very different…because it is extremely important, because this AIDS project receives special financing, 'so they take special effort for patient,' they take a lot of …. 'fund to take care of the patient. Ok? More services are free, the medication are free. It's different for the other people, for other patient, you have to pay, you have to buy medication'*
68	Regine	Sa depann de pasyan-an, paske menm si di pasyan-an ke, gen pasyan ki vini ki pa pon dutou; lè m di w pa bon dutou nan langaj donk ki pa kapab, memm si ou eksplike pasyan sa-a mil fwa, fòk ta gen yon sikològ ki pou pale ak pasyan-an, pale ak pasyan-an, anvan l konprann; donk gan de pasyan ou konn oblije ou kategorik ou chwazi pou li	*…this depends on the patient, because even if you tell the patient that, there are patients that come, that are not good at all. When I say not good at all, it's in language. So if I can't, even if you explain to the patient a 1,000 times, you would need a psychologist to speak with the patient, speak to the patient, before he can understand.*
68	Fritz	Epi gen w' pwoblèm de communication medsen pasyan. E pwoblèm sa, li gen plusieurs facteur ki ladan l'. Li gen yon facteur éducatif, sa vle di, pasyan li plus souvan se yon moun ki pa trop byen formé. Sa vle di yon moun ki pa vrèman konn li,	*But the reality is that in Haiti, there is a problem, a problem of communication. And there is a doctor-patient communication problem. And this problem, it has many factors in it. It has an*

		oubyen pou l' konprann. Epi medsen an li menm, nan fòmasyon l', yo pa t' aprann li tou pou l' desann nan nivo pasyan. Eske w' wè sa m' di w' la ? Nan fòmasyon medikal en Ayiti, yo te plus fè medsen an rete nan nivo medsen. Eske w' wè sa m' di w' la ? Bèl blouz euh, blouz blanch, zuzu, bwodè. Sa vin koz pwoblèm kominikasyon an poze. Certaine fois, pasyant lan konn pa konprann medsen an. Eeee epi medsen an li menm konn pa jugé nécessaire pou l' eksplike payant lan. Men an reyalite, lè l' pa jugé nécessaire, se pa fòt li, se par incompétence. Parce que nan formation l', li pa gen kapasite pou l' desann nan nivo pasyant lan pou l' eksplike l' pou l' konprann. Parce que nou pale deux langues, nou pratike medsin nan, nou aprann medsin nan an fransè, tandis que n'ap pratike l' avèk pasyan ki pale kreyòl. Pwoblèm langue lan, li yon ti jan poze.	*educational factor, that means, the patients are more often people who are uneducated. That means a person who doesn't really know how to read, or how to understand. And the doctor himself, in his training, they didn't teach him how to get down to the patient's level.*
69	Delner	Bon! Se ka-a ki w oblije antre nan langaj pasyan-an. Se sak rele yon med-sen kominotè, se sak rele yon medsen piblik, de sèvis piblik. Se sak rele yon med-sen de famiy; pou w eseye konprann langaj moun lan, fò w antre nan kilti moun lan, fò w antre nan sivilizasyon l, paske li gen dwa vini li eksplike w yon bagay men ou pa konprann li. Men fò w eseye antre pou w konprann sa l di w lan. …paske an Ayiti sitou, kounye ya tandans la kòmanse chanje, otrefwa yon medsen pasyan-an te konn toujou pè pou l eksplike l sa l genyen. Li gen yon tandans ke, li gen yon santiman de pè, yon santiman denferyorite…	*Well! …you have to get into the language of the patient. That is what is called a community doctor, that is what is called a public doctor…that is what is called a family doctor; for you to understand the person's language, you have to enter into the person's culture, you have to enter into his world, because he has the right to come and explain something to you that you don't understand. But you have to try to understand what he is trying to say to you…especially because in Haiti, now it's starting to change, but other times, the patient used to always be scared to explain what is wrong. …He had a feeling of fear, a feeling of inferiority…*

69	Marjorie	Hum… Moun yo renmen kòm si yon moun la k'ap pale avè yo, k'ap eksplike , k'ap eksplike yo kisa pou yo fè. K'ap ba yo, k'ap ba yo de ti ide sou, sou maladi a. Trè souvan, moun nan gen yon pwoblèm, yo pa eksplike moun nan kisa l' genyen. Moun nan bezwen ke fò w' eksplike li genyen, ki kote pou l' al fè, kisa pou l' fè. Eske bagay li a se yon bagay k'ap geri, kisa l'ap fè. Li bezwen yon oryantasyon. Li bezwen yon moun ki pou koute l'. Ki pou gide li.	*The people like someone there to speak to them, to explain, to explain to them what to do. To give them ideas on [their] illness. Very often, the person has a problem, they don't explain to the person what he has. The person needs for you to explain….he needs an orientation. He needs someone to listen. He needs someone to guide him.*
69	Louise	Eee, eee plis sajès, plis sajès paske e nou bewzen sa paske gen nan nou menm ki pa jwenn lanmou, nan kote nap viv byen gen defwa ou anvi deplase lakay ou pouw chita ak yon moun ki konnen kiyes ou ye pouw pale paske gen defwa ou santi tet ou lou.Eee plis sajes plis konpreyansyon pou yo ka konpran moun, pou yo ka konprann.	*…more kindness because…we need this, because there are of us who didn't find love in the places that we lived. Well, there are times you wish to leave your house to sit with someone who knows you to talk, because there are times when you feel like your head is heavy.…more kindness, more understanding, so that they can understand us, so they can understand.*
70	Francoise	Depi tranbleman de tè a èske m wè yon chanjman ? M te wè depi tranbleman de tè a m wè yo tap mache pou yo bay medikaman, epi timoun ki merite vaksen yo ba yo, epi bay popilasyon an medikaman.	*Have I seen a change since the earthquake? I have seen since the earthquake. I saw them walking around to give medication, and children who needed vaccinations got them, and [they] gave the people medication.*
70	Nickson	Aprè tranbleman de tèr la, oke olye de moun nan sèlman fòw pran…ou konsiderasyon antouraj li osi, paske moun nan ou konnen ke sonw moun ki ap gen moun ni…gen moun ki pèdi tout fanmi yo ou gendwa panse moun nan ou konnenn mouri jus pou chèche konnen èske moun sa te gen moun ki mouri nan tranbleman de terre la…ki mouri…si gen moun ki mouri ou pral nan konpasyon…oke…Avan ou pat petèt…bon…ou pat petèt nan tout bagay sa yo, ou pat nan tout	*…After the earthquake, instead of the person only…you have to consider his entourage as well, because you know that person had people…there were people who lost their whole family…before, you weren't interested in all of that…you didn't consider all of that…you were a little more impersonal.*

		konsiderasyon sa yo, moun nan vini madanm saw genyen depi konbyen tanw malad…bon…un p'tit peu trè zenpersonèl, men petèt avèk eee….tranbleman de terre la petèt ou antre…ou pran plus konsiderasyon pou vi pasyan pou vi malad la pou antouraj li sak rivel son w istwa ou vin fè konnen a istwa pèsonèl aprè tranbleman de terre la.	
71	Caroline	Ok kòman kominike fason mwen kominike avèk yo, kòmsi mwen vin kòmsi m vin santi mwen ke m vin plus près yo , mwen vin plus proche yo de kòmsi ke mwen ba yo plis mwen menm kòmsi plis tan poum tande yo,mwen pran plis tan tou pou yo pataje ide yo ansanm avèm poum eseye komprann yo poum eseye tande yo fè moun nan fè moun nan o mwen retounen rekomprann yo.	*Ok the way you communicate with them, like I became, like I felt I became closer to them, I became closer to them, like, I gave them more of myself, more of my time listening to them. I take more time to share ideas with them, to understand them, to try to listen to them. Make the person more or less understand themselves again.*
71	Hugh	Bon wi sè di ke nan moman tranbleman de tè a, nou te wè gen de seri de moun ki pa t wè lajan, ki te wè vi moun, ki te eseye bay tout yo menm, ki pat menm panse a lajan, swa yo pra l bay yon patisipasyon oblije wè vi moun pou yo sove lavi yon seri de moun. Yo menm tou yo te ka nan sitiyasyon an paske gen yon seri de medsen, ki mouri nan Pòtoprens, profesè ki mouri, gen tout kalite moun ki mouri, nan tranbleman de tè a, egal lè w wè yon moun vini la a ki pa menm medsen, si se leve yo ka leve detwa moun mete yo kouche atè nan lakou a, si se pote yo ka pote yo al nan sal epi yo bay patisipasyon pa yo, depi nan moman sa-a yo te wè vi moun parapò a kantite moun ki mouri yo vin wè bon, moun k ap pran pòz kòm si yo pa kanmarad yon seri de moun, yo vin wè pa gen sa pase lè w gade atè P toprens, Jakmèl, Leogan ou wè yon pakèt moun k anba dekonb yo. Vin wè vi a pa gen anyen, yo vin wè	*…in the moment of the earthquake, we saw a series of people who did not care about money, who cared for people's lives, who attempted to give their all…and them too, they could have been in the situation because there were a series of doctors, who died in Port-au-Prince, professors who died, there were all kinds of people who died in the earthquake…people who pretend not be friends of a certain type of person, they came to see that that wasn't there, because when you saw the grounds of Port-au-Prince, Jacmel, and Leogane, you saw all the people under the rubble….after the earthquake there has been change. People came to see that no matter what your status is compared to another, they see that they have*

		patisipasyon pa yo, kèlke swa fason an yo oblije bay patisipasyon pa yo, pou yo kapab ede kretyen vivan, ou sove lavi l depi lè sa-a tout moun vin wè pa gen anyen serye nan vi a se sèl ti souf la, depi lè sa tout moun vin wè pa gen anyen enpòtan, epi tout moun ap bay patisipasyon pa yo, petèt avan tranbleman de tè a gen moun ki te gen dwa pran yon ti pòz, li pa kanmarad moun, men apre tranbleman de tè a gen chanjman, moun nan wè kèlke swa nivo parapò a yon lòt, li wè pou l kolabore avè l.	*to partner with you.*

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