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Rural Haitian Women's Experiences With Poor Health Through Poverty

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2017

Abstract

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BS, University of South Florida, 2013

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

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Abstract

People living in rural Haiti lack access to basic health care services due to poverty. Rural poverty in Haiti particularly affects women's health because Haiti has had the highest maternal mortality and infant mortality rates in the Americas, in addition to some of the worst health statistics in the Western Hemisphere. The purpose of this phenomenological study was to cultivate a greater understanding of the poverty factors that affect access to health care services specifically among poor women living in rural Haiti. This study was based on the social ecological model for population health development, theorizing that a person's health is influenced by factors at multiple levels including intrapersonal, interpersonal, organizational, and public policy and community roles. The main research question in this study explored potential relationships between poverty and poor health among women in rural Haiti as it relates to health status and access to health care services. Using semi structured interviews and Moustakas's modified van Kaam 7 steps method for phenomenological analysis, I explored the poverty phenomenon and various aspects of the lived experiences of 12 poor women in rural Haiti. The research findings indicated that factors such as barriers to health care, alternative health care, and poor living conditions contributed to the way that the poverty phenomenon affects the health and lives of poor rural Haitian women. The social change implication for this study includes development of new programs in rural Haiti that improve access to basic health care services together with more accessible clinics and staff on call 24 hours a day, 7 days a week that will positively influence women's health outcomes and health status.

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Dedication

"I can do everything through Christ, who gives me strength." Philippians 4:13.

I dedicate this dissertation to God, my heavenly father and creator, who has been by my side from Day 1 and has given me continuous strength to persevere until the end. I would not have made it to the finish line without God's grace, wisdom, strength, and mercy. I also dedicate this dissertation to my loving husband, my best friend, and my biggest supporter, Dr. Marc Donald Felix, who have endured this journey with me. I am grateful for his neverending words of encouragements and inspirations.

I also want to dedicate this dissertation to my parents, Marie Geraldine Pierre and Eliphete Pierre, who instilled in me the value of education, the tools of true freedom. As immigrants, your sense of hard work and determination is motivating and inspiring. Thank you both for believing in me and supporting me. To my sisters Mydarly Philippe Francesca Pierre, and Loudwige Roseme, my nieces and nephews, and to my brothers Ancy Pierre, Renaldo Pierre, Ricardo Felix, Casey Felix, and Stanley Felix: "Never give up on your dreams. Reach for the moon and never stop learning." Lastly, I dedicate this dissertation to my study participants, poor women in rural Haiti struggling with poverty. I appreciate your honesty and willingness to assist with this important research. May God wrap His arms around you and let you feel how much He loves you.

Acknowledgments

"I know that was you, God! Thank you so much." First and foremost, I would like to thank my loving God for all the trials I have endured and the blessings in my life. Second, I would like to thank my soulmate and husband of 9 years, Dr. Marc Donald Felix, for his unconditional support. There are so many things I want to say to you, all of which can be summarized in just three words: I love you. Thanks for everything. I would also like to thank all my supportive friends and families that God blessed me with who were always there to help me pray.

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Chapter 1: Introduction to the Study

Introduction

As of 2014, Haiti was one of the poorest nations in the Western Hemisphere (World Bank, 2016). Haiti is the paragon of poverty and underdevelopment compared with other countries that surround it (Alsan, Westerhaus, Herce, Nakashima, & Farmer, 2011; Lundahl, 2015). The origins of this poverty started since Haiti was first colonized in 1492 (Alsan et al., 2011). Today, over 50% of the country's inhabitants live in poverty (Alsan et al., 2011; Lundahl, 2015), and 2 out of 3 people are unemployed relying on insufficient farming and depleted resources (Alsan et al., 2011; Klasen & Lamanna, 2009). Because poverty commonly leads to poorer health, it is expected for the majority of Haiti's populations to have poor health (Alsan et al., 2011; Currie, 2009). This research study attempted to confirm and support this belief with a particular emphasis on rural Haitian poverty. Although the association between poverty and health is evident and vigorous owing to the subsequent peer-reviewed data, this qualitative study helped explore to what extent poverty affects health in rural Haiti while considering social factors.

This study addressed a gap in the literature by focusing on poor women living in rural Haiti and the health disparities affecting them. In this chapter, I present an overview of this qualitative phenomenological research study starting with a summary of rural poverty literature and the research problem. Next, I provided a discussion of the purpose of the study, the theoretical framework, and the research question. This chapter will then proceed with a summary of the nature of the study and types and sources of data for this

study. Lastly, this chapter included a discussion of the definitions, assumptions, and the scope of the problem, limitations, and significance of the study.

Background

The most significant poverty disparity in Haiti is contingent upon geographical characteristics between cities and rural areas (Fawzi et al., 2010; Gage & Calixte, 2006; Perry et al., 2007; Preidis et al., 2010; Sloland & Gerbian, 2006; World Bank, 2016). In Haiti, poverty is primarily in rural areas at 75.5% as opposed to 40.8% in urban areas (Fawzi et al., 2010; Preidis et al., 2010; World Bank, 2016). The inequality between rural and urban populations in Haiti is apparent. Haitian rural residents live below the country's extreme poverty line of less than $2 a day and lack access to essential services such as quality water for drinking, education, and health care accessibility (World Bank, 2016). Moreover, almost 72% of rural households live in a state of poverty over an extended period, compared to roughly 20% in the urban areas (Fawzi et al., 2010; Preidis et al., 2010; World Bank, 2016). This dissimilarity implies that poverty inequality is on the rise in the rural areas while declining in cities. This poverty difference is especially disturbing as more than half of the population inhabits the rural areas of Haiti. For instance, more than 47% of Haitians live in rural Haiti while only 22% live in urban areas (World Bank, 2016). Haiti poverty percentages decreased from about 32% to 25% beginning in 2000 through 2012, owing to improvements made predominantly in the cities (World Bank, 2016).

Researchers have highlighted that rural Haitian women living in poverty tend to underutilize health care services due to barriers such as lack of access to health care

services (Celik & Hotchkiss, 2000; Falkingham, 2003; Fawzi et al., 2010; Gage & Calixte, 2006; Magadi, Eliya & Martin, 2003). Moreover, the barriers frequently addressed by researchers include medical services challenges and medical supplies shortages (Barnes-Josiah, Myntti, & Augustin,1998; DeGennaro & Ginzburg, 2011; Gage & Calixte, 2006; Horvath, 2005; Hinman et al., 2011; Perry et al., 2007; Prentiss, Prentiss, Zervo, King, & Zervos, 2011; Sweeney, 2010; Waring & Brown, 2005), Haitian health beliefs and traditions (Allen et al., 2013; Desrosiers & St Fleurose, 2002; Khoury, Kaiser, Keys, Brewster, & Kohrt, 2012; Miller, 2000; Rahill & Rice, 2010; Zook, Graham, Shelton, & Gorman, 2010), lower socioeconomic status and inconsistencies in the distribution of income (Currie, 2009; Fawzi et al., 2010; Klasen & Lamanna, 2009; Padgett & Warneckle, 2011; Pampel, Krueger, & Denney, 2010; Urrutia et al., 2012), and lower educational attainment and employment opportunities leading to poorer health status (Anderson, 2007; Ballantine & Spade, 2011; Cutler & Lleras-Muney, 2006, 2010; Farmer & Castro, 2004; Gibbons & Garfield, 1999; Kim, Muntaner, Chung, Benach & EMCONET Network, 2010; Klasen & Lamanna, 2009; Mackay, Cousins, Kelly, Lee, & McCaig, 2004; Niraj & Dhiroj, 2016; Padgett & Warnecke, 2011; Smith, Paulsen, Fougere, & Ritchey, 1993). Based on the literature, I began my study with the assumption that Haitian women in poverty encountered several barriers that prevented them from accessing basic health care services to maintain good health. Given the large focus in the literature on the barriers rural Haitian women in poverty encountered in accessing health care services, I conducted a study focused on the lived experiences of rural Haitian women living in poverty and its influences on their health status and access to health care

services. By discovering to what extent rural poverty affected women's health status and their access to health care services, health providers and the Haitian government can use the findings from this study to assist in reforming their health services strategies and poverty-related policy and efforts to align with the needs of this population.

Problem Statement

Poverty is among the greatest risk factors for poor health worldwide (Sridhar, 2016). In most parts of Haiti, poverty and its influences on health have still been a major public health problem, as 59% of the population lives below the poverty line (Patrick et al., 2013; Sridhar, 2016). Rural people are at a particular disadvantage because poverty rates have often been greater and more persistent in Haiti's rural areas (United Nations Development Programme [UNDP], 2013). For example, in 2013, approximately 3.07 million poor people lived in rural areas, and more than 58% of the households in rural areas lived in absolute poverty (UNDP, 2013). While several studies have reported a strong connection between poor health and poverty in various areas of Haiti (Alsan et al., 2011; Gelting, Bliss, Patrick, Lockhart, & Handzel, 2013; Hinman et al., 2011; Mosley & Miller, 2004; Perry et al., 2007), the authors failed to make a distinction between the effects of poverty on women, and the role of specific socioeconomic factors such as educational level, income level, and employment status.

While the precise definition of poverty has not been universally established, there are indications of how to identify it. The most recurrent definition and cause of poverty are related to socioeconomic status (Niraj & Dhiroj, 2016). Socioeconomic status–based poverty has often been measured and expressed in long lasting conditions related to a

lack of financial income and access to and distribution of resources, in addition to lower employment and education and poorer health (Niraj & Dhiroj, 2016). Indeed, socioeconomic status and poverty are intimately intertwined. Although in Haiti variance in socioeconomic status, including inconsistencies in the distribution of income and access to resources affected everyone, poor women living in rural areas were particularly affected (Padgett & Warneckle, 2011). Fawzi et al. (2010) found that the economic situations reflected the widespread and extreme poverty in rural Haiti with 44% of women living in substandard housing conditions (mud shelters, thatched houses), and only 32% of households had a latrine, an indicator of pervasive poverty.

The cost of services, as well as socioeconomic factors such as education level, income level, occupational status, and household means, are stronger predictors of health-seeking behavior and the use made of health services than the ease of access to health services (Fawzi et al., 2010; Padgett & Warneckle, 2011; Urrutia et al., 2012). The effect of poverty on health status and the accessibility of health care services has not been extensively explored at the rural region level, particularly in developing countries such as Haiti (Gage & Calixte, 2006). According to existing studies by Magadi et al. (2003) and Falkingham (2003), living in poorer areas decreases the likelihood an individual will seek and receive adequate health care services. Although researchers have examined the effect of poverty on health in Haiti, I found a gap in the literature concerning rural Haitian women facing challenges in assessing regular health care services due to poverty. Indeed, there are persistent negative relationships between poverty and the usage of health care services in rural Haiti (Falkingham, 2003; Magadi et al., 2003). The findings presented at

this point suggested that strategic efforts and improvements targeted at the poorest rural areas can influence health-seeking behavior and the usage of health services. This awareness led me to propose a study that provided an in-depth understanding of the lived experiences of rural Haitian women in poverty and the role poverty played on their health status and access to health care services.

Purpose of the Study

The purpose of this phenomenological qualitative study was to cultivate a greater understanding of the factors that impact access to health care services that ultimately affect the overall health of poor rural Haitian women. While other studies have supported the relationship between poverty and poor health, a significant gap in the research literature was found regarding the impacts of poverty on health status and access to health care services among rural Haitian women (Perry et al., 2007; Sridhar, 2016). To address this gap, I examined the connection between poverty and lack of access to health services that led to poorer health among rural Haiti women, emphasizing socioeconomic factors attributable to poverty such as educational level and employment status. Therefore, the ultimate objective of this research study was to offer evidence for expanded advocacy efforts that would help improve the current structure of health services in rural Haiti.

Research Questions

In this study, I investigated the poverty phenomenon of rural Haitian women. The central research question for this study was as follows: What role does poverty play in the poor health of women in rural Haiti? From this, two subquestions were derived: What are the lived experiences of Haitian women in poverty and its impact on access to health care

services? How do socioeconomic factors such as lack of employment and educational resources impact the health status of poor Haitian women living in rural Haiti?

Theoretical Framework

The theoretical foundation for this study was Bronfenbrenner's social ecological model (SEM) for population health development and behavior (Bronfenbrenner, 1979). According to the SEM, factors at multiple levels, including intrapersonal, interpersonal, organizational, community, and public policy, influenced a person's health (Glanz, Rimer, & Viswanath, 2008; McLeroy, Bibeau, Steckler, & Glanz, 1988). A direct implication of this framework on poverty sustained population wide effects that addressed a person's risk factors such as cultural norms, as well as economic, social, and environmental systems and created conditions for poverty to occur (Centers for Disease Control and Prevention, 2015). For example, on the individual level, demographic variables such as gender, age, education status, marital status, employment status, income level, and the number of children influence the likelihood of women's poor health related to the day-to-day role of poverty (Duncan, 1996; Thurston & Vissandjée, 2005). At the community level, the possibility of maternal stress or constant worry is much greater in rural areas or areas where low maternal support and high poverty are manifested (Duncan, 1996; Thurston & Vissandjée, 2005). At the societal level, social determinants of health or variables such as public policy, economic opportunity and deprivation, and social standards impacted the level of health services and resources available to women living in rural Haiti (Edmond, Randolph, & Richard, 2007).

Population health determines individual health, in the sense that one cannot examine individual health status without examining the larger perspective that shaped them. The SEM for this study, which is a population health approach, allowed for a comprehensive view of individual's health. It showed how different constructs influenced health status and provided an explanation to understand the intrapersonal, interpersonal, organizational, community, and public policy factors that influenced the health status of poor women living in rural Haiti. Therefore, I have presented the SEM as a contextualist theory build on Bronfenbrenner's (1979) theories in a way that I found useful for my research, as it explained the relationship between economic deprivation, poverty, and women's health.

Nature of the Study

The nature of this study was qualitative using a phenomenological approach to explore and understand the lived experiences of rural Haitian women in poverty facing poor health status and difficulties with access to basic health care services. The goal of this qualitative phenomenological research was to fully understand the essence of the experiences as perceived by each so as to describe and interpret the essence and meaning of the phenomenon (Creswell, 2009; Merriam, 2009). The phenomenon of interest in this study was poverty. Data collected from poor women in rural Haiti addressed experiences related to poverty that, in turn, have an impact on health.

The source of data collection for this study included individual semistructured interviews with poor women in rural Haiti to gain an understanding of the underlying reasons for people's experiences, attitudes, and choices. I analyzed the data based on

Moustakas's (1994) modified van Kaam seven steps method for phenomenological analysis. This method helped me achieve a greater understanding of rural women's experiences with poverty. Common terms that have special meaning in the study are defined in the next section.

Definitions

Health services availability: Access to basic care and essential primary health care services, family planning and nutrition, and vaccination and infectious disease services to poor and underserved communities (U.S. Agency for International Development [USAID], 2016).

Haitian health care belief: A belief system accompanied by cultural, spiritual, and traditional values that significantly influences a person's perception of health practices and health care orientation (e.g., home remedies, vodou practitioners and healers knows as *bokor* for male and *mambo* for female, *doktèfey* [herbalist], *doktèzo* [bonesetters], *pikirist* [injectionist], and *fanm saj* known as traditional birth attendants (Desrosiers and St Fleurose, 2002; Khoury et al., 2012; Rahill and Rice, 2010).

Poverty: The state of being poor "lacking adequate means or resources (material, cultural, social) to live comfortably" and as "want of the necessities of life" ("Poverty," 2016).

Rural poverty in Haiti: Impoverished rural families living below Haiti's poverty line on less than $2 a day and lacking access to sufficient basic resources (UNDP, 2014).

Rural Haiti: Home to 60% of Haiti's population with 89% of people living in poverty and 68% of people living in extreme poverty with insufficient access to basic goods and services (International Fund for Agricultural Development, 2008).

Socioeconomic status: Combined total measure of one's education, employment, and economic and social standing in relation to others in a society (American Psychological Association, 2016).

Assumptions

The first assumption of this study was that the participants answered honestly and truthfully during the interviews because anonymity was well-preserved and participation was voluntary. Another assumption was that participants provided enough relevant data of their experiences in the interview and understood the questions asked of them. I also assumed that participants were representative of most rural Haitian women living in poverty.

Scope and Delimitations

The scope of this study involved 12 Haitian women who were 18 and older, from rural areas of the Northwest Artibonite regions of Haiti experiencing poverty and lacking access to basic health care services. Poor women who live in other rural regions of Haiti may have experienced poverty and lack access to health care services, but this study was not generalizable to other rural regions due to geographic limitations, sample size, and its homogeneity. Another delimitation was the inclusion of only participants with the demographics mentioned above and the exclusion of participants from other demographic groups such as men and children.

Limitations

The limitations of the study included the following: (a) the study used a small sample size, and therefore the results may not be generalizable beyond that specific population; (b) the study interviewed participants experiencing the same phenomenon; (c) the study focused on poor women in rural Haiti reporting on their experiences, so knowledge produced may not be generalizable to other people, other settings, and other nations; (d) the study utilized snowball sampling technique as a second strategy to select interview participants and follow up with participants; (e) some of the participants were not able to read and write in their native language; and (f) the nature of the chosen research method for this study (qualitative phenomenology) imposed limitations on the replicability of the study. Because qualitative studies occur in the natural settings, replicability is extremely difficult (Patton, 2015).

Significance

In rural Haiti, poverty has a highly significant impact on people's health. Authors Sweeney (2010) and Horvath (2005) found that Haiti's rural hospitals lacked medical supplies, equipment, and medical responses, leading to poorer health among its populations. Researchers Hinman et al. (2011) confirmed that people in rural Haiti living in poverty with minimal access to sanitation and clean water were at greater risk of acquiring diseases. Although there are myriad challenges to conquer for Haiti to lose its rank as the poorest country in the Western Hemisphere, poverty reduction initiatives can allow the country to take a step toward achieving more widespread poverty-related

development goals and interventions to encourage better health status among the Haitian people.

There has been limited awareness of the emerging significance of poverty and its impact on people's health, particularly poor women living in rural Haiti, as poverty circumstances and social inequalities place rural Haitian women at dramatically increased risk of poorer health (Mosley & Miller, 2004). As a result, this research study could have implications for education efforts, public health interventions, and policies aimed at addressing poverty and its consequences on women's health in rural Haiti. For example, poor rural Haitian women would benefit from programs and services that build on the strength and improvement of poverty-related interventions as this study could provide the necessary information to reduce poverty.

Positive Social Change Implications

Consistent with Walden University's definition of positive social change, any research that relates to efforts and ideas to create positive social change and focuses on real-world applications of these efforts and ideas has positive social change implications. For this research, exploring essential policy-oriented factors such as poverty and socioeconomic status and their influences on rural Haitian women's health status and access to health care services could advocate for positive social change strategies and efforts both at the individual and institutional level. Findings could ultimately make significant contributions to improving public health conditions, particularly for Haitian women living in poverty and for advancing the Haitian society as a whole. McLoughlin and Young (2005) stated that public health research has gradually improved the context

and content of poverty-related policy considerations. The findings of this study could help develop new programs for women in rural areas to improve their health status.

Summary of Chapter 1

In this chapter, I explored poverty as a variable, and introduced the theoretical framework of the study, the Bronfenbrenner's (1979) SEM for population health development and behavior (Bronfenbrenner, 1979). This chapter provided a detailed analysis of Haiti, the significance of the study, and the social change implications of the study such as the creation of awareness towards the effect of poverty and improvement of poverty alleviation programs. This chapter discussed research questions, which covered the issue of women's poor health and its connection with the level of poverty, in addition to the effects of all the variables of poverty on poor health. This chapter also discussed the definitions of terms and the assumptions of the study.

Chapter 2 offered a review of literature based on the concepts related to the problem being investigated, the research questions, and an in-depth overview of the Bronfenbrenner's (1979) theoretical framework that grounded this study. Chapter 2 also offered an overview of the literature related to research methods that have been used in studies about poverty and health. In Chapter 3, I discussed the methodology and procedures used to collect data for the study. The results of the study are discussed in Chapter 4. Lastly, chapter 5 provided an interpretation of findings and recommendations for further study.

Chapter 2: Literature Review

Introduction

The purpose of this qualitative phenomenological study was to understand women's lived experiences with poverty to cultivate a greater understanding of the factors that impact access to health care services that ultimately affect the overall health status of poor rural Haitian women. By focusing on women in poverty, the findings of this study addressed barriers to accessing health care services such as lower socioeconomic status and lack of employment opportunities. The ultimate goal of this research was to provide an evidence basis for continued advocacy efforts that would improve the current structure of accessing health services in rural Haiti.

The relationship between poverty and poor health has been greatly researched, but less focus has been given to the lived experiences of rural Haitian women living in poverty and their challenges with accessing health care services. To address this significant gap in the literature, I examined the connection between poverty and lack of access to health services that led to poorer health among rural Haitian women, emphasizing on socioeconomic factors attributable to poverty such as lower educational attainment and employment opportunities. The findings from the studies presented in this review provided a lens for understanding how women view and understand rural poverty, which influenced their access to health care services and other health-seeking behaviors. The literature review started with an overview of the search strategies. Then, I discussed the literature on concepts related to the research question and the SEM theoretical

framework used to ground this study. To finish, I presented a review of literature related to research methods that researchers have used in studies about poverty and health.

Literature Search Strategy

In obtaining the literature for the study, I explored many databases to find peer-reviewed literature related to poverty and health. I particularly emphasized on the sociological context of poverty highlighting deprivation such as lack of access to health services, lower employment opportunities, and lower education attainment, underlining any sources within the last 6 years. The principle electronic databases used to find professional, peer-reviewed literature were as follow: Academic Search Complete, EBSCO, SocIndex, and PsycINFO, ProQuest Central, ScienceDirect, MEDLINE, CINAHL, and Thoreau databases. I also used other search engines such as Google Scholar and Sage Full-Text Collection to find additional articles on the subject of poverty and health, the topic of inquiry impacting socioeconomic status, education, and employment. Many of the databases mentioned above offered a different range of limits that controlled my searches by specified parameters such as publication year. This feature was helpful in eliminating dates that were outside of the date published limit. I only went back 6 years in the literature; therefore, my search strategy focused on articles in the last 6 years (since 2010) to limit the years and to capture more up-to-date information for my research.

The criteria that were used throughout my keyword search involved a combinations of terms including *poverty and health, poverty in Haiti, Haitian women in poverty, poverty and its impacts on education status, poverty and its impacts on*

employment status, poverty and its impacts on socioeconomic status, poverty and its impacts on health care services accessibility and usage, medical services challenges in rural Haiti, lack of medical supplies and health professionals in Haiti, Haitian health beliefs and traditions, underutilization of health care in Haiti, and *poverty and its impacts on health status and access to health care services*. The search terms mentioned above generated much needed results and several articles identified with the topic matched precisely. Still, I used keywords and controlled language to narrow my search options to full-length text and peer-reviewed articles to compare, contrast, and confirm interpretations of various articles on the extent of how poverty impacts one's health. Using peer-reviewed articles also helped me recognize the methodology best suited to answer the overarching research question of the study. In the subsequent literature review, I highlighted research conducted using the SEM for health behavior (Andersen & Newman, 2005; Larios et al., 2009), barriers to access and usage of health services (Derose, Gresenz, & Ringel, 2011), and preference for seeking traditional care (Allen et al., 2010). The first area of literature covered the theoretical framework for the study.

Theoretical Framework Overview: SEM

Ecological factors have been demonstrated to influence health. In 1979, Bronfenbrenner published the ecological system theory to explain how individual and community health are dependent upon several aspects of the person, community, and the environment (Bronfenbrenner, 1979). The theory emphasized that individual development is influenced by the different types of environmental systems. The theory is made up of four systems that influence an individual's behavior: microsystem,

mesosystem, exosystem, and macrosystem (Bronfenbrenner, 1979). Microsystems are the social interactions between people and their immediate environment (Bronfenbrenner, 1979). The mesosystem is the interaction among multiple individual microsystems in which a person functions (Bronfenbrenner, 1979, 1999). The exosystem is the external environment that only indirectly affects one's development (Bronfenbrenner, 1979, 1999). The macrosystem represents the values, traditions, and laws that are considered significant in the person's culture (Bronfenbrenner, 1979, 1999). Through this study, I sought to understand women's experiences with poverty to cultivate a greater understanding of its impact on the health of poor women living in rural Haiti. Accordingly, the SEM helped to understand why and how the environment influences the health behavior of rural Haitian women.

Over the past 10 years, the leading causes of mortality and morbidity have changed from contagious illnesses to chronic illnesses that have a range of social, psychological, and behavioral foundations (Perry et al., 2007). It is, therefore, pertinent to persuade health and medical professionals to consider both human and environmental factors when figuring out health, proposing treatment for diseases, and creating public programs and interventions that will bring about the best profound and long-term health advantages for people. Indeed, Bronfenbrenner (1977) demonstrated the usefulness of SEM for improving and preventing poor health as he provided illustrations of just how ecological models and perspectives have been confirmed to impact health. The SEM was instrumental for this study because it shed insight on the difficult problem of poor health and appealed to health and medical professionals' attention to the individual aspects of

the social environment that affected health in Haiti by separating it into a component of interacting systems (Edmond et al., 2007). Health and medical professionals must recognize that people's interpersonal, intrapersonal, organizational, public policy, and community interactions, activities, and roles influence their health behaviors, opinions, and compliance to health managements or treatments (Edmond et al., 2007; Glanz et al., 2008). In the subsequent sections, I provided examples illustrating relevant ecological concepts and their connections to health.

SEM Related to Health Care Services: Accessibility and Usage

Because poor health in terms of health status and access to health care services among Haitian women living in poverty was the fundamental concept being explored in this study, I utilized the SEM for population health development and behavior, which focused on an individual's environmental and social factors (Bronfenbrenner, 1979; McLeroy, Bibeau, Steckler, and Glanz, 1988; Stokols, 1996). The SEM of health incorporated the social aspects of Haitian women and the environment in which they live that are related to their wellbeing and health status. For example, in rural Haiti, the impact of the physical environment and road conditions on people's health is of considerable importance, as transportation for easy access to medical services is lacking (Gage & Calixte, 2006). Distance and poor road conditions negatively impact women's decision to seek health and use health services (Gage & Calixte, 2006). Indeed, region or area differences in less developed countries influenced health-seeking behaviors (Celik & Hotchkiss, 2000; Falkingham, 2003; Gage & Calixte, 2006; Magadi et al., 2003). In rural Haiti areas, the availability and accessibility of health facilities and health care providers,

as well as the adequacy of the transport system, are relevant to a woman's decision to seek care such as pregnancy and delivery care, breast, and cervical care, and other women-related complications or health issues to reduce maternal morbidity and mortality (Gage & Calixte, 2006). As a result, distance is a relevant factor in the use made of health services and a woman's decision to seek preventative care.

Distance influences on health. The impact of distance is attributable to whether or not a woman uses available health services. In rural Haiti, lack of public transport, poor road conditions, challenging landscape or geography, the cost of travel, and time are all attributable factors that affect the use of health services (Gage & Calixte, 2006). Falkingham (2003) and Celik and Hotchkiss (2000) suggested that health facilities accessibility can increase care seeking in a community, especially for prenatal care. I agree with Gage and Calixte (2006) that distance and poor road conditions are significant constraints on health-seeking and service utilization decisions. As stated by Fawzi et al. (2010), I would add that the cost of services, as well as socioeconomic factors such as education level, income level, occupational status, and household means, are stronger predictors of health-seeking behavior and the use made of health services than the ease of access to health services. The effect of poverty on the accessibility of health care services has rarely been explored at the rural region level, particularly in developing countries such as Haiti (Gage & Calixte, 2006). According to existing studies by Magadi et al. (2003) and Falkingham (2003), living in poorer regions or areas decreases the likelihood to seek and receive adequate health care services. Therefore, there are persistent negative relationships between poverty and the usage of health care services (Falkingham, 2003;

Magadi et al., 2003). The findings presented at this point suggested that efforts to reduce and repair inconsistencies in health-seeking decision and behavior in rural Haiti would require the improvement of strategies targeted at the poorest areas to influence health-seeking behavior and the usage of health services.

SEM Related to Medical Services: Challenges in Rural Haiti

Using Bronfenbrenner's (1979) SEM perspectives for human behavior and development, it is recognized that in the Haitian culture, rural women's exposure to daily poverty through environmental or community conditions and characteristics influenced their health behavior and health outcome (Bronfenbrenner, 1979; Gage & Calixte, 2006; Prentiss et al., 2011). For example, in Haiti, hospitals, health care centers, clinics, and infirmaries are predominantly located in the cities or the larger villages, making it difficult for people to receive adequate care (Gage & Calixte, 2006; Prentiss et al., 2011). Therefore, the possibility for the country's government to offer and maintain health services has remained limited (Prentiss et al., 2011). However, Sweeney (2010), Horvath (2005), and Prentiss et al. (2011) suggested divergent viewpoints on Haiti's inadequate access to health care and basic medical supplies. Their findings were comparable, indicating that Haiti's rural hospitals lacked medical responses, equipment, and supplies, which led to poorer health among its populations. Indeed, health is influenced by community and environmental forces. To this extent, the framework of SEM showed relevance in the ecological or environmental concentration of poverty.

According to the Harvard Center for Population and Development Studies (2010), more than 55% of health care in Haiti are provided by nongovernmental organizations or

missionary work. Hardly any physicians operated nonprofit clinics, most of which were found in the cities. Whether public or private, medical services in Haiti are disproportionately located in the larger cities or the metropolitan areas of Port-au-Prince, the country's capital (Harvard Center for Population and Development Studies, 2010). Another study by Perry et al. (2007) presented substantial evidence of a strong relationship between health systems in an impoverished setting compared with national rates. The findings raised the question of whether the observed differences in mortality rates are attributed to poor medical services in Haiti. Barnes-Josiah et al. (1998) declared that maternal mortality is affected by three main issues. These included a delay in a woman's decision to seek care, to easily access care, and to receive adequate care as a result of medical services challenges. Barnes-Josiah et al. also found several ways to address maternal mortality and health outcomes in a community. For example, by providing employment to village women, their health, worth, and standing in the community will be restored (Barnes-Josiah et al., 1998). Moreover, giving village women paying jobs also increased their knowledge of the conditions of the local population in addition to increasing their income, which is a known predictor that can improve the health of women on several fronts (Barnes-Josiah et al., 1998).

SEM Related to Haitian Health Beliefs and Traditions

A unique characteristic of ecological models is a shared, corresponding emphasis on both the environment and the individual (Golden & Earp, 2012). In the origination of the ecological model, Bronfenbrenner set apart more specific aspects of the ecological model and identified the mechanisms by which their relationships influenced health

(Bronfenbrenner, 1977). For example, the ecological model accentuated the importance of people's practices, perceptions, and dispositions that affected their health (Bronfenbrenner, 1977; Naaldenberg et al., 2009). Haitian's traditional practices, a case in point of a person's perspective, has been associated to ill-health (Allen et al., 2013; Desrosiers & St Fleurose, 2002). Indeed, traditional practices have an impact on people's health because Haitians are strong believers of self-treating by way of using traditional medicine such as massage, herbal preparations, home remedies, and local healers or vodou practitioners for health issues or complications (Khoury et al., 2012; Miller, 2000). That is a problem because this practice caused Haitians not to see the importance of preventative care (Khoury et al., 2012; Miller, 2000). Because pregnancy is not considered an illness, some women may not understand the significance of prenatal care (Buser & Lori, 2017). Traditional medicine, especially in rural Haiti, continued to be the answer for people's health needs, explanation for sicknesses, and a convenient and inexpensive treatment method traditions (Allen et al., 2013; Desrosiers & St Fleurose, 2002; Khoury et al., 2012; Miller, 2000). Based on the Haitian belief system, there are five recognized levels of healers including vodou practitioners (bokor for male, mambo for female), herbalists (doktèfey), bonesetters (doktèzo), injectionist (pikirist), and traditional birth attendants (fanm saj) (Desrosiers & St Fleurose, 2002; Rahill & Rice, 2010). Barnes-Josiah et al. (1998) found that between 65% and 70% of Haitian women, particularly in rural areas, gave birth at home attended by traditional birth attendants.

It is very common for Haitians to call upon vodou practitioners, herbalists, bonesetters, injectionist, and traditional birth attendants to treat health problems and

complications (Allen et al., 2013; Desrosiers & St Fleurose, 2002; Khoury et al., 2012; Miller, 2000; Rahil & Rice, 2010). Khoury et al. (2012) suggested that the Haitian belief system significantly influenced their perception of health and disease prevention; for instance, people tie a knot in their toes for diarrhea relief. During the 2010 cholera epidemic, some patients arrived at the clinic with knot in their toes hoping it would stop the diarrhea. Those who had died from cholera were found with a knot in their toes because they refused to seek treatment at a hospital as they believed they could stop the diarrhea or be healed or cured using a vodou practitioner's methods and processes (Zook et al., 2010). To emphasize the Haitian's vodou practice and belief, some people even apply a lemon behind one's belt or on a baby's abdomen to stop illnesses from the devil (Allen et al., 2013; Desrosiers & St Fleurose, 2002; Khoury et al., 2012; Miller, 2000). Sometimes they used dead people's teeth or a dead dog's teeth to make a necklace to stop vomiting because a vodou practitioner suggests it to them (Desrosiers & St Fleurose, 2002). They think a seizure disorder is an attack from the devil, and a vodou ceremony must be performed for healing instead of seeking medical care (Khoury et al., 2012; Miller, 2000). As stated by Khoury et al., only after multiple unsuccessful visits to vodou practitioners will a Haitian seek medical help from a health professional. These traditional practices and belief system limited the utilization of hospitals, modern treatments, and health care professionals (Miller, 2000). As a result, ecological models suggested that health care providers be mindful of the role traditions played in one's health matters and how it is expected to guide health behaviors (Golden & Earp, 2012; Stokols, 1996).

Other Studies Supporting the SEM

For this study, I explored social factors to determine to what extent they influenced the health among rural Haitian women using the SEM, a theory-based model that provided details on how to understand the various impacts of personal and environmental elements that influenced health outcomes, and to understand the multiple levels of interactions between individual behaviors and environmental factors. Further studies that were not necessarily related to Haiti used SEM to address its role in health behavior and their associations with the environment such as environmental factors and drinking patterns and behaviors (Gruenewald, Remer, & LaScala, 2014); condom use (Larios et al., 2009); and commuting (Feuillet et al., 2015; Giles-Corti & Donovan, 2002; Ogilvie, Mitchell, Mutrie, Petticrew, & Platt, 2002).

In their study testing the SEM approach for alcohol use and drinking patterns, Gruenewald et al. (2014) evaluated associations of behavior characteristics and demographic of individual drinkers as well as environmental factors at the city-level to assess the use of drinking contexts and drinking patterns. Using multi-level statistical analyses and an ecological sample of 50 geographically distinct cities with populations from 50,000 to 500,000 people, the authors used Measurements Archival city-level alcohol outlet data combined with individual survey data from 50 cities in California, USA to identify psychosocial characteristics, community conditions, individual demographic and regularities in drinking patterns and drinking contexts.

The results of the study indicated that personality characteristics and individual demographic were linked to drinking and drinking environments. SEM stipulated that the

greater the individual drinking characteristics and community alcohol accessibility, the more it affected the use of drinking contexts and drinking patterns. For instance, higher impulsivity was correlated to higher drinking frequencies ($b = 0.2001$, $z = 2.088$, $P = 0.023$) and recorded quantities ($b = 0.0151$, $z = 2.009$, $P = 0.026$) and consistently more drinking at bars ($b = 0.0332$, $z = 2.016$, $P = 0.026$) and parties ($b = 0.1712$, $z = 2.770$, $P = 0.004$). In conclusion, accessibility of alcohol in a community and individual drinking behaviors acted together to impact drinking levels, patterns and the use of drinking environments. The results provided support into the large effects of community settings on drinking correlating SEM with high-risk drinking behaviors.

Another study by Andersen and Newman (2005) found that environmental and individual factors influenced one's health-seeking approach towards accessing and using medical services. Through this study, SEM demonstrated the integrations between health determinants and outcomes and the social environment. Also, Larios et al. (2009) explored the relevancy of the SEM for health behavior in a study focusing on contextual factors related to condom use behavior in a sample of female sex workers living and working in Tijuana, Mexico. Utilizing SEM as a theoretical framework, the study used a multilevel approach to explore how individual, interpersonal, and environmental factors impact condom use in women, mainly female sex workers who are at a greater risk to contract sexually-transmitted diseases. Their findings pointed toward the necessity for a multidimensional approach to sexually transmitted diseases and HIV prevention that addresses both environmental and individual determining factors of condom use, including alcohol and drug use, the location of work and poverty.

Feuillet et al. (2015) conducted a cohort study in France focusing on the association between active commuting and health that showed the relative effect of the specific environmental characteristics of the community characterized by the significant positive relationship among active commuting and the built environment. The result revealed that active commuting is positively associated with the built environment and the socioeconomic environment suggested that the SEM conceptual framework can be applied to target public health policies to be more efficient in promoting active commuting. This validated findings by Giles-Corti and Donovan (2002) in Australia, and Ogilvie et al. (2008) in the UK. For example, Ogilvie et al. emphasized that in urban vicinities of Glasgow, 17.8% of the total difference in active commuting was explained by personal associations and 20.2% when environmental determinant factors were added. In conclusion, these authors determined that the inclusion of environmental variables did alter the influence of the personal factors on the relationships studied. Accordingly, the multiple levels of the ecological model such as individual and environmental factors influenced health behaviors. Therefore, their results on active travel or commuting health behaviors, namely the interchangeability of the relative influence of individual and environmental variables, suggested the significance of considering the ecological contextual framework.

In conclusion, SEM appealed to the health behaviors that transcend different contexts. For instance, environmental influences, a consistent theme across all of the authors' standpoint in this review, has been presented as one mechanism linking environmental factors to health outcomes and behaviors. Similarly, for Haiti, those who

lived, functioned, and worked in poverty environments will likely experienced poorer health. Through this association, SEM confirmed the associations between health determinants, outcomes, and behaviors and the social environment. Eventually, this can encourage a change in policies that diminish poverty in and across environments to promote individuals' health.

SEM Implications and Limitations

Although I have shown that ecological models influenced health and health behaviors and they were more powerful as behavior-specific, I still need to consider opposing views for behavior-specific ecological models. For example, two studies tested the perceived physical environment variables and combined impacts of the SEM to explained walking (Rhodes, Brown, & McIntyre, 2006) and physical activity (McNeill, Wyrwich, Brownson, Clark, & Kreuter, 2006). Although McNeill et al. (2006) found that both physical and social environment elements were associated with physical activity; Rhodes et al. (2006) found that psychosocial factors entirely clarified the impacts of physical environment variables. Then again, one should note that both of these studies depended on self-report processes, and the authors only examined a limited number of factors. Consequently, these variables cannot be considered definitive.

I will now offer support for what is perhaps my most controversial claim, which is that ecological models are bound to difficult practical problems because the standard of shared interaction of both individual and environment is not easy to measure and analyze (Walker et al., 2006). Identifying environmental factors that are unambiguous to a health behavior is a challenge in the practice of ecological models as lessons learned by means

of one behavior, such as, promoting walking to work, may not be used for a seemingly related behavior, such as, promoting jogging (Rhodes et al., 2006; Yeom, Fleury, and Keller, 2008). Indeed, health behavior is reinforced and strengthened by several characteristics of the individual's social and physical environment (McNeill et al., 2006). Everything considered, people have remarkable adaptive abilities to change health behavior even in the unhealthiest conditions; therefore, the emphasis on just the environments should not indicated that people were not keenly involved in modifications of their health or circumstances (Merzel & D'Afflitti, 2003).

Summary

Empirical findings from across disciplines embraced a far-reaching ecological framework of health in which obstacles emerging from individual-environment interactions considered an essential contributing factor to health. As a result, this can foster improvement of a more widespread health awareness that can bring about more targeted health interventions. The SEM could mainly influence the basis for health system improvement and development in Haiti for several reasons. First, the SEM facilitated a complex approach to health care policymaking (Stokols, Pelletier, & Fielding, 1996). This change is particularly important for Haiti given that poverty reduction policy is the number one priority for the country's government and its people (Satti, Raymonville, Marsh, & Smith-Fawzi, 2011). Of course, the problem is far more complicated than poverty reduction policies. The SEM offered numerous benefits over other models of health. Contrary to other theories wherein health is regarded as a result of merely social phenomena, ecological models incorporated and integrated other key

features such as psychological and biological factors across phenomenon (Bronfenbrenner, 1979; McLeroy et al., 1988; Stokols, 1996). For that reason, SEM can result in more comprehensive understanding and knowledge of health and can offer the basis for further health interventions for individuals living in underprivileged environments. This study contributed to access to health care policymaking debate and hopefully will inspire a renewed effort by all appointed government officials to accelerate progress by 2020 and beyond. Certainly, Bronfenbrenner's ecological theory was instrumental because it sheds insight on the difficult problem of poverty and the environment and its impact on health outcomes, behaviors, and health care services accessibility and usage. Poverty in Haiti and its role in poor health status, and access to health care services will be explored next.

Literature Review Related to Key Variables and Concepts

Poverty in Haiti

People in countries with less financial resources are more prone to be undernourished and less healthy (Fawzi et al., 2010). The impacts of poverty in Haiti are multifaceted. People are usually unable to see a doctor because they live on less than $1 a day (Alsan et al., 2011). According to the latest household survey from the Institut Haïtien de Statistique et d'Informatique (2012), more than 6 million out of 10.4 million (59%) Haitians live under the national poverty line of US$ 2.42 per day and over 2.5 million (24%) live under the national extreme poverty line of US$1.23 per day. In effect, Haiti has the highest wealth inequality in the Caribbean and South America. The wealthiest 20% of the Haitian people retain possession of more than 63.9% of its overall

wealth, whereas the poorest 20% of the population possessed 1% or less (Institut Haïtien de Statistique et d'Informatique, 2012). Poorer people tend to seek health care services much less (Levine, 2007). Doctor shortages in Haiti only make matters worse (Larson et al., 2015; Rosseel, Trelles, Guilavogui, Ford & Chu, 2010). For example, there are only 25 doctors available per 100,000 people in Haiti as of 2009 (Larson et al., 2015; Rosseel, Trelles, Guilavogui, Ford & Chu, 2010). In the United States, that number is 230 doctors per 100,000 people, which is almost ten times the number in Haiti (Gelting et al., 2013; Levine, 2007). This doctor shortage is particularly significant when the country's likelihood to acquire an epidemic or outbreak is higher than average (Gelting et al., 2013).

Poverty in Rural Haiti

Poverty percentages in rural areas remained unchanged. For instance, only 11% of Haiti rural area households have access to electricity and quality water supply compared to 65% in the country's cities (Gage & Calixte, 2006; Perry et al., 2007; Sloland & Gerbian, 2006). Moreover, only 17% of the population in rural areas utilize improved hygiene and sanitation practices, whereas 47% of urban areas employ these methods (World Bank, 2016). Gage and Calixte (2006) confirmed that rural poverty is more advanced and more challenging than in the cities due to medical supplies shortages, lack of access to health care services, and lower employment and educational opportunities. Basic health is rare and difficult to acquire. Hence, offering access to health care services, employment, and educational opportunities, to a country's rural areas is a critical strategy in promoting health improvements for its populations. Despite the fact that Haiti is trying

to withstand the improvements accomplished and expand more opportunities for its people, the country will require further public improvements directed at rural areas and create more ways to manage its limited resources effectively toward improving access to basic health care services and employment opportunities.

Poverty in Other Developing Countries

Poverty is certainly among the major issues in other developing countries. Developing countries represent 85% of the world population and compose of approximately 75% of the total land area (Alvaredo & Gasparini, 2013; Anand & Segal, 2008). When compared to a developed country with a high-income economy, a regular developing country is characterized by excessive wealth inequalities, advanced levels of resources deprivation, and greater dispersion in individual wellbeing (Alvaredo & Gasparini, 2013; Anand & Segal, 2008). Hence, minimizing inequalities are paramount in fighting poverty in developing countries. Although high poverty is a pervasive aspect of the developing world, it is not an irreversible issue. In many developing countries, there were substantial evidence indicating a reduction in the levels of poverty in various dimensions over the last decades (Alvaredo & Piketty, 2014; Azevedo et al., 2011; Cameron, 2002; Deaton, 2005, 2010; Gasparini & Gluzmann, 2012; Skoufias & Suryahadi, 2000; Soares, Osório, Soares, Medeiros, & Zepeda, 2009). These countries were commonly categorized into the following geographical zones: Eastern, Southern, and Central Asia, North Africa, the Middle East, and Latin America and Sub-Saharan Africa (Alvaredo & Gasparini, 2013; Anand & Segal, 2008). However, changes in income disparity have increased in some countries and decreased in others. This section

reviewed literature illustrating some basic poverty and economic statistics, and demographic backgrounds of several developing countries apart from Haiti.

Although poverty is a persistent factor in a developing country's wealth, and resources, its austere intensity differed across countries. For example, a study by Gasparini and Gluzmann (2012) calculated inequality data from the Gallup World Poll 2006 and found that Latin American countries have the highest income inequality percentage in the world at 49.9%, slightly greater than South Asian countries at 48.9%, and Eastern Asian countries at 47.3%. The researchers further indicated that Central Asian countries are the least unequal at 41.7%. This study revealed the differences among developing regions regarding income inequality and economic deprivation. This disparity showed that even within the developing world, poverty levels differed in some countries compared to others.

Skoufias and Suryahadi (2000) revealed that decrease regional inequalities in Indonesia caused a 15% drop in the country's gross domestic product (GDP) reducing household per capita expenditure resulting in a sharp increase in poverty. Although Skoufias and Suryahadi provided ample evidence that a drop in a country's GDP increases poverty, Cameron's (2002) research on equity and the distributional impact of Indonesian development indicated that inequality and poverty linked the fluctuations in the sociodemographic structure of the population instead of a reduction in the country's GDP. Alvaredo and Piketty (2014) conducted a study that considered the poverty issue from a regional angle and showed that income disparity and poverty are particularly higher in some region than others solely because regional inequality is greater. Alvaredo

and Piketty are saying that disparity and unjust distribution of wealth reflected the fact that views and opinions about poverty are not only determined by national differences but by regional difference as well.

In an in-depth study exploring the determining factors of inequality in Brazil, Soares et al. (2009) emphasized the role of income disparities as a direct determinant of poverty. Their findings indicated that labor incomes or earnings disparities were related to educational progress that occurred a couple of decades ago that considerably improved the proportion of unskilled and skilled workers. Several researchers, Deaton (2005, 2010) and Azevedo et al. (2011), have confirmed that in addition to an increase in education, a reduction in sectoral and spatial labor market breakdown can also impact earning inequality. I agree with Deaton (2005, 2010) and Azevedo et al. (2011) that an increase in education influenced earnings inequality, and would add that an increase in minimum wage is another significant force behind income disparity, assuming that the minimum wage established the standards for both skilled and unskilled workers' earnings.

Socioeconomic Status Impacts on Health Status

Socioeconomic status–based poverty is often measured and expressed in long-lasting conditions related to a lack of financial income and access to the distribution of resources, in addition to, lower employment and education, and poorer health (Niraj & Dhiroj, 2016). Niraj and Dhiroj (2016) said that socioeconomic status and poverty are intimately intertwined. Although in Haiti, variance in socioeconomic status, including inconsistencies in the distribution of income and access to resources affected everyone, poor women living in rural areas were particularly affected (Padgett & Warneckle, 2011;

Urrutia et al., 2012). Studies by Fawzi et al. (2010) and Urrutia et al. (2012) found that the economic situations reflected the prevalent and extreme poverty in rural Haiti with 44% of women living in substandard housing conditions (mud shelters, thatched houses), and only 32% of households had a latrine, an indicator of pervasive poverty. Debates over poverty and socioeconomic status were inclined to dominate discussions of housing conditions. But these debates obscured the far more important issue of sexually transmitted diseases caused by lower socioeconomic status. For instance, Fawzi et al. (2010) indicated that due to economic hardship in rural Haiti, women are more inclined to take part in sexual relationships out of economic necessity and that this inclination is increasing the widespread of HIV infections. Hence, women in Haiti are more vulnerable economically with limited access to financial resources compared with men. Agreeably, gender disparities are often intricately related with the socioeconomic situation in a given country (Klasen & Lamanna, 2009). Therefore, gender disparity and economic vulnerability increased the risk of diseases and infections among women in rural Haiti (Fawzi et al., 2010; Klasen & Lamanna, 2009; Urrutia et al., 2012).

Socioeconomic status is increasingly related to health outcomes, diseases and deaths across countries and cultures (Currie, 2009; Pampel et al., 2010). People with lower socioeconomic status repeatedly have worse health status than individuals with higher socioeconomic status (Currie, 2009; Pampel et al., 2010). The extent and the steadiness in the impacts of socioeconomic status on health outcomes specified that a person's position in the social ladder is significantly related to health behaviors, beliefs, and practices. While socioeconomic status is commonly measured by factors such as

education level, income, and occupational status, the literature indicated other dimensions and levels of socioeconomic status that must be considered by health professionals. For instance, a qualitative study conducted by Pampel et al. (2010) found that education, occupational status, and income independently influenced a person's mental health. Correspondingly, several other researchers specified that residing in a poor community or area is linked with poorer individual health (Currie, 2009; Smith et al., 1993). The literature suggested that concern about various levels and dimensions of socioeconomic status can deliver a broader understanding of health-associated phenomena, thus resulting in improved prevention interventions.

To better understand the population and individual health, one can use the different levels and dimensions of socioeconomic status and recognized that particular magnitudes of socioeconomic status are more consistent predictors of health, reliant on environmental factors. For example, Currie (2009) found that regional socioeconomic status is concomitant with poorer health because people living in low economic areas have added challenges in accessing and using medical services, have more social challenges associated with disparities in the distribution of wealth and resources, and have poorer health status. In relation to the researcher's findings, lack of access to the social capital, funds, and social support resources have also been found to be an imperative element for explaining health disparities among communities or regions in a country. Having argued that socioeconomic status, a factor of the social environment, encouraged poorer health in individuals, I considered rival views that indicated a more multifaceted connection to the damaging impacts of socioeconomic factors. Khoury et al.

(2012) found that a person's perception, beliefs, and sense of control also contributed to the impacts of lower socioeconomic status. Their results aligned with the SEM that different environmental integrations and personal perceptions are useful in influencing health behaviors (Allen et al., 2013). Because socioeconomic status factors are not directly subject to prevention intervention, other mediators linking socioeconomic status to health such as environmental strain, life stress, social support, lifestyle, and access to health care can be targeted to reduce the negative effects of socioeconomic disadvantages.

Poverty Impacts on Access to Health Care Services

Hinman et al. (2011) addressed professional medical shortages in their study. For example, after the devastated 2010 earthquake that shattered Haiti's main cities and killed more than 220,000 people; over 1.3 million Haitians were affected by extreme poverty with lack of access to medical care, medical supplies, sanitation, and clean water causing a greater burden of poverty and diseases, including a cholera outbreak (Hinman et al., 2011). The results of this study attested to the fact that people living in poverty have minimal access to sanitation, clean water, and medical care, and are at greater risks of acquiring diseases. Although the study confirmed that poverty had a negative effect on the health of people living in Haiti, it is important to consider two relevant methodological-related objections that affected this study's findings. Firstly, the associations may have been significantly different had the sample consisted of people of all ages (Hinman et al., 2011). Another relevant limitation to the study is that it was not longitudinal, following the participants before the earthquake (Hinman et al., 2011). It is

important to create more health services facilities and hire more medical professionals in Haiti mainly because most people lack access to basic medical care (Horvath, 2005).

Next, I addressed the topic of poverty concerning medical supplies shortage. Even before the earthquake struck Haiti, it was one of the least developed and poorest countries in the world (Sweeney, 2010). The lack of medical equipment and supplies in Haiti hospitals resulted in medical response shortages, and its populations are at greater risks of acquiring diseases (Horvath, 2005; Sweeney, 2010). In the end, Haiti hospitals lack infrastructure to deliver effective health care. Taken together, the results from this study indicated that poverty played a major role in health and health-seeking. Even before the earthquake, Haiti's hospital staffs were bombarded by the scarcity of resources and the obsolete conditions of the hospital. For example, a typical laboratory in a Haiti hospital functioned so poorly that it is practically impossible to acquire an accurate and complete blood count (Waring & Brown, 2005). Moreover, medical supplies are so limited that they ran out of oxygen supplies most of the time (Waring & Brown, 2005). Twice-daily antibiotics medicine for severe meningitis infections was often only administered once a day owing to staff shortages (Waring & Brown, 2005).

Staff shortages are not anything uncommon in Haiti. Just 10 years ago, in 2005, there were merely 1,950 doctors working in the entire of country of Haiti, and only 750 of them employed in the public sector (Waring & Brown, 2005). The result indicated approximately 8 hospital beds, 1 nurse, and 3 doctors, per 10,000 people, which come to nothing comparing to the recommended WHO objectives of 23 health care workers per 10,000 inhabitants (Waring & Brown, 2005). Indeed, the minimal numbers of health

professionals worsen the public health in Haiti. As stated by DeGennaro and Ginzburg (2011), there is an association between in-hospital mortality and the number of nurses; the association is similar for under-five child survival and maternal mortality and the number of health care professional. The authors are saying that fewer health care professionals are equivalent to an infective public health system. For instance, health care worker shortages mean lower childhood vaccination rates, lower percentage of deliveries or births attended by trained health personnel, lower treatment rates of malaria and tuberculosis and increased amount of time people have to wait before they can see a health personnel; as a result, people rarely pursue medical treatment until the condition reaches emergency levels (DeGennaro & Ginzburg, 2011).

Employment Opportunities and Health

Employment status and the various aspects of a person's work influenced health behaviors and health outcomes as working people are in better health than their counterparts. Other than the fact that working people are healthier, many aspects of work affected the health of individuals and communities (World Health Organization [WHO], 2007). Workplace environment directly and indirectly impacted a worker's health. Negative aspects of work such as poor compliance with safety and health regulations and poor working conditions may influence workers' psychophysiological health and undermine hindered positive health practices (Mackay et al., 2004). Evidently, the problem is far more complicated than negative aspects of the work environment. Experiencing employment permanency is also linked with fewer chronic illnesses, lower

risk of coronary heart disease, better health status and better health behaviors (Kim et al., 2010).

Haiti has zero social safety net without welfare services, unemployment benefit, homeless shelters, unemployment insurance, country supported health care or universal health care, and subsided services such as public transportation and food security excluding that circulated by foreign relief organizations such as CARE, Red Cross, and the World Food Program preventing people from falling into poverty beyond a certain level (Farmer & Castro, 2004; Gibbons & Garfield, 1999). Moreover, the minimum wage for an average worker in Haiti is about US$3 a day, and most workers work only 6 months a year (Klasen & Lamanna, 2009).

There has been an increased interest in socioeconomic determinants and their impact on health status. Occupational status is a socioeconomic determinant of health that surpassed medical care (Kim et al., 2010). Disparities in health resulting from unemployment are closely related to different varieties of social disparities comprising of disparities in wealth and education (Kim et al., 2010). Unemployment and job insecurity in Haiti is associated with a range of negative health effects. Haitian women, in particular, are at a greater risk to be unemployed than men (Kim et al., 2010; Klasen & Lamanna, 2009; Padgett & Warnecke, 2011). The percentage of employed individuals living on US$2 per day has increased in numbers, reaching 1.37 billion worldwide in 2006 (WHO, 2007). Additionally, in reference to the 550 million working poor worldwide, an estimated 330 million, or 60% are women (WHO, 2007). Socioeconomic inequalities including poverty, lack of employment opportunities and low education, may

have an important impact on health status as a result of lifestyle behaviors, as well as access to health care and health services (Klasen & Lamanna, 2009).

In conclusion, to regulate employment disparities, appointed government officials need to not only reallocate resources affecting social stratification, but also have an influence on the life experiences of different social groups including opportunities for better access to health care services. Despite the fact that there is abundant literature on occupational status, working conditions, and health, this literature hardly focused precisely on the significant role played by occupational status as a key socioeconomic determinant in shaping health disparities. This study was a contribution toward filling the gaps in knowledge, hoping that a better understanding of these elements simplified the task of making well-informed governmental decisions over such a critical issue.

Education Status and Health

"Education is development. It creates choices and opportunities for people, reduces the twin burdens of poverty and diseases, and gives a stronger voice in society. For nations, it creates a dynamic workforce and well-informed citizens able to compete and cooperate globally – opening doors to economic and social prosperity. Education enables people to transform their lives and the society in which they live."

-Pakistan International Human Rights Organization, 2016.

Education is essential to socioeconomic improvement and has a profound influence on people's health. Poorer educational attainment generated poorer health because the fact remained that people with a higher education level have a higher health status and lower morbidity and mortality rates from the most prevalent chronic and acute

diseases, not dependent on labor market components and basic demographics (Cutler & Lleras-Muney, 2006, 2010). Education's influences on health encompassed multifaceted aspects that are likely to include one's social environment, family background indicators, demographic indicators and wealth distribution related to higher levels of education (Cutler & Lleras-Muney, 2006, 2010; Glanz et al., 2008). Moreover, education is one of the keys determining factors that placed people within specific ecological perspectives as education is the motivation behind each ecological level; therefore, the SEM offered a perspective on the various ways in which education is related to one's life experiences, and health outcomes (Ballantine & Spade, 2011; Cutler & Lleras-Muney, 2006). Because better education initiated better health, addressing the manners by which inequalities in education explained the inequalities in health can be valuable to bringing awareness to public policymakers in Haiti (Anderson, 2007). In their study, Cutler and Lleras-Muney (2006) explored statistical analyses relating to the association between health and education. The authors examined numerous different factors for why education impacts health. At first, they thought that differences in income, an obvious factor, could explain the differences in health outcomes as higher education bring about higher income, which allowed one to better access to health care and health care services. Cutler and Lleras-Muney debated the unlikeliness that income and health care and health care services can entirely justified the relationship between education and health, especially because many of the health behaviors they evaluated were independent of access to health care. The authors reckoned that disparities in income represented roughly 20% of the effect of

higher educational attainment on health behaviors. They found a strong connection between education and health.

Cutler and Lleras-Muney (2006) developed a grounded theory in that education is responsible for improving critical thinking skills, which, in turn, will provide individuals with better access and understanding to health information. Cutler and Lleras-Muney grounded theory was beneficial because it provided insight on the issue of education and health. What this means is that more educated people are more inclined to make better use of acquired health information when making health-related choices and decisions. Cutler and Lleras-Muney found that educational advancement accounted for a total of 30% of the impact that education has on individual health behaviors. The authors are saying that better education has a positive effect on health for those with a higher socioeconomic status compared to those who are poor or have a lower socioeconomic status. In conclusion, since higher education attainment encouraged better health, policies to expand education can be resourceful at improving population health.

Haiti Education: Quality, Enrollment, and Retention

Haiti education has steadily proved problematic. The quality of education in Haiti is poor due to lack of trained teachers and resources for teachers training programs, outdated curricula, poor facilities and unsatisfactory textbooks; as a result, test scores are poor causing an increase in grade repetition and dropout rates (Smith et al., 1993). Moreover, because public schools are rare, especially in rural areas, parents often delay a child's education until he or she becomes more mature to walk the long journey to the closest school (USAID, 2007, 2015). In addition to the barriers and challenges mentioned

above, school costs are rising, and education is excessively expensive. More than 50% of Haitian children do not attend school due to financial challenges, and nearly 30% of children attending elementary school will not make it to middle school as 60% or more will drop out of school before age 12 (UNICEF, 2008; USAID, 2007, 2015). In Haiti, a good education cost between US$70 to US$80 per child annually (UNICEF, 2008; USAID, 2007, 2015). Consequently, only 29% of Haitians 20 and above have a middle school level education (USAID, 2015). To a great extent, parents simply cannot meet the expenses of sending their children to school, especially if they have more than one (World Bank, 2016). In 2015, USAID examined the household vulnerability in Haiti and found that other than school quality related problems, parents every so often pulled their children out of school as a consequence of economic distress.

Haiti Education Quality and Literacy

As a country, Haiti continuously faced an extreme teacher shortage. Presently, Haiti needs over 2,000 trained teachers every year to reach the objective of universal education (U.S. Library of Congress, 2009). Unfortunately, they only trained 350 teachers every year (U.S. Library of Congress, 2009). Most public school teachers in Haiti lack basic training, and nearly 80% lack the required preservice education training (USAID, 2015). Unquestionably the problem is far more complicated than qualified teachers. For instance, the Haitian government expenditure in the education sector is less than average as the country expands less than 2% of its GDP each year on education (Wolff, 2008; World Bank, 2016). With the initial school enrollment rate of only 67% and an adult literacy rate of 61%-64% for males and 57% for females, education in Haiti

remained a major problem for sustained economic and social development (Central Intelligence Agency Factbook, 2015). Despite progress in the government's commitment to support the country's public education, barriers in funding and teachers training remain dominant. These challenges place a generation of Haitian youth at risk of not acquiring basic education needed to be successful. To address the education crisis, the Haitian government must make universal education a priority (WHO, 2002).

Summary

This literature review confirmed that multiple studies had considered poverty concerning the widespread views of destitution such as homelessness, welfare and gender disparities, and wealth inequality (Klasen & Lamanna, 2009; Niraj & Dhiroj, 2016; Padgett & Warneckle, 2011). While these poverty notions described above are true, the issue of poverty in Haiti surpassed such notions of an unfair welfare system and income disparities. Instead, the poverty-related argument people need to strengthen is that many developing countries, Haiti in particular, are still facing the burden of both chronic and communicable disease rates, and high morbidity and mortality rates directly related to poverty, income inequality, poor access and usage of health services, socioeconomic status inequalities, sustained periods of unemployment, and poor literacy rates that exceed those of other undeveloped countries. Indeed, many factors combined can impact population health. This chapter discussed how people's health status is determined by several factors including socioeconomic circumstances and the environment. To a great extent, factors such as where people live, the state of their environment, their income and education level, and their access and use of health care services have considerable

influence on their health. Poverty and immeasurable socioeconomic inequalities and lack of access to basic social services, continued to be a central concern in Haiti. By exploring essential policy-oriented factors such as poverty and socioeconomic status and their influences on Haitian women's health status and access to health care services, this study can advocate for social change strategies both at the individual and institutional level to ultimately contribute to the improvement of public health situations and advance the Haitian society. The next section of this chapter provided literature related to the research method of the study.

Literature Review Related to Research Methods

The qualitative approach to research focused on understanding a phenomenon from a closer perspective (Creswell, 2009). In agreement with Creswell (2013), there are five different approaches used in qualitative research: ethnography, case study, narrative research, grounded theory, and phenomenology (p. 69). These qualitative research approaches focused on seeking, understanding, describing and discovering meaning through the rich description that the people within those environments give to their experience (Creswell, 2003, 2013). Qualitative phenomenological research strived to describe the lived experiences of individuals and provided justification concerning the phenomenon (Creswell, 2009, 2013). To understand the phenomenon as part of a particular context, qualitative researchers focused on understanding the meaning that individuals have constructed. The qualitative research builds and supports concepts, abstractions, and theories instead of testing existing theory (Flick, 2002).

Phenomenological Research Methods

Phenomenology approach defined the common meaning for many people of their lived experiences of a phenomenon (Embree, 1997; Moustakas, 2004). A researcher using this approach focused on describing what all individuals have in common as they experience a phenomenon; this description consisted of what they experienced and how they experienced it (Embree, 1997; Moustakas, 2004). Besides, phenomenology is an interpretive process in which the researcher makes an interpretation of different meanings (Creswell, 2003, 2013). In relations of methodology, Trochim (2001) emphasized that "A qualitative phenomenological investigation was emphasized as a school of thought that focused on people's subjective and reflective experiences and interactions with their environment and people in that environment" (pp. 159-160). Authors Embree (1997) and Neill (2007) acknowledged fragments of the phenomenological approach as it took into consideration the importance of the unobservable. Certainly, phenomenology accentuated the exploration and examination of the universal essence of a phenomenon including various aspects of lived experiences (Embree, 1997; Neill, 2007). The next section illustrated the utilization of phenomenological approaches in the literature.

Qualitative Phenomenology in Other Studies

A growing number of qualitative studies used phenomenological methods to explore the lived experiences of the participants (Martins, 2008; Newton & Turale, 2000; Underlid, 2007). Martins (2008) conducted a descriptive phenomenological study to explore the experiences of homeless people with the health care system. The interviews conducted were tape-recorded, transcribed, and then analyzed using the descriptive

phenomenological method as phenomenology was the philosophical underpinning of this research. The results of this research revealed that living without essential resources can compromise the health of homeless people. Newton and Turale (2000) examined poverty and the economic circumstances of 17 students in Australia using phenomenology as the methodology for data collection and analysis. The authors considered different ways of measuring poverty including self-perception, social criteria, dependence on a government allowance, and the poverty line. The results indicated that poor students saw their wellbeing and self-worth affected by poverty as they struggled to escape a cycle of indebtedness and risked academic standards by working.

Another qualitative study with a sample of 25 long-standing recipients of social security was interviewed using phenomenological methods to explore experiences of insecurity among people living in relative poverty in a wealthy society (Underlid, 2007). The study found that poverty and related factors gave rise to a sense of insecurity to which participants respond with apprehension and anxiety. Casey, Eime, Payne, and Harvey (2009), isolated a selection of relating elements such as individual, intrapersonal, organizational, and environmental that effect physical activity participation and involvement of young girls in rural Victoria, Australia. The researchers conducted a series of four separate focus group discussions founded on a sociological model of health. They use a sample size of 34 teenagers asking each one about their participation and involvement in physical activity or exercises. The semistructured interviews were recorded and transcribed to generate and formulate probable themes and subthemes (Casey et al., 2009). The results showed indication of the correlation between

interpersonal, intrapersonal, and organizational factors and their effect in physical activity participation and involvement in teenagers within a rural context (Casey et al., 2009).

The purpose, method procedure and theoretical framework of the above-mentioned qualitative study are important characteristics, and components of qualitative studies since these features are unique characteristics impacting the distinctive nature of qualitative research design (Baxter & Jack, 2008; Miles & Huberman, 2004; F. E. Moore, 2010). The purpose of the study was to comprehend the essence of experiencing a phenomenon, in this case, physical activity participation and involvement among rural teenagers (Casey et al., 2009). The SEM used in this study was appropriate because it offered an opportunity for in-depth analysis of the complicated specifics of physical activity performance and considered these performances in the context of the teenage girls' life instead of isolating it from other elements of their life (Casey et al., 2009).

Casey et al. (2009) used unstructured or informal interviewing in their study which involved direct interaction between four focus groups and the researchers. Informal interviews are useful in qualitative research to explore a research problem or subject matter more in-depth and to understand human behavior (Creswell, 2009; Mays & Pope, 1995). Casey et al. applied qualitative techniques and procedures to approach the topic thoroughly so as to measure it by quality instead of quantity; thus, these processes eventually guided them in gathering and examining data associated with their research questions and topic. To analyze their data for the study Casey et al. used coding. In qualitative research, coding is an assign phrase or word that summarizes significant data (Creswell, 2009).

Summary

The literature provided examples where qualitative approaches have been used to carry-out poverty and health related studies. Qualitative studies are particularly useful for identifying unexpected outcomes owing to the subjective nature of the design and methods (Patton, 2015). The use of phenomenological methods allowed researchers to remain open about the phenomenon (Rudestam & Newton, 2015). Another common characteristic of qualitative phenomenological research is its ability to use open inquiry; an approach researchers used to learn about a phenomenon, both expected and unexpected (Creswell, 2009; Patton, 2015). This specific contribution is valuable in finding out unanticipated data (Creswell, 2009; Patton, 2015).

Various published studies use phenomenological methods to examined poverty and health to form a relatively coherent picture (Casey et al., 2009; Martins, 2008; Newton & Turale, 2000; Underlid, 2007). While there have been various qualitative phenomenological studies of poverty and health, very few are in Haiti; as a result, my study filled that gap. Given the consistent literature on poverty and health using a qualitative phenomenological method, it is of interest to examined poverty and health in Haiti using the same approach. The usage of the qualitative phenomenological design in this research provided participants with a platform to describe their lived experiences and to tell their story. This qualitative study using phenomenological methods identified intangible factors that were not readily apparent to help better understand, deduce and interpret the complex lived experiences of women in poverty.

Chapter 2 Summary

The research studies in this literature review confirmed that poor rural Haitian women are more inclined to experience poorer health due to higher poverty in rural environments, lack of access to and underutilization of health services, professional health shortages, lower education attainment and lower socioeconomic status. In this literature review, poverty-related factors including income level, educational level, and socioeconomic status were consistently found to influence health (Alvaredo & Gasparini, 2013; Anand & Segal, 2008; Azevedo et al., 2011; Barnes-Josiah et al., 1998; Deaton, 2005, 2010; Fawzi et al., 2010; Gelting et al., 2013; Klasen & Lamanna, 2009; Urrutia et al., 2012). Researchers contributed the cause of poorer health to higher poverty in rural environments. The literature included studies that reflected the barriers rural people face in seeking and accessing health services. Researchers have also examined the poverty and health among rural Haitian women through a qualitative lens and less through a quantitative lens. In this study, I also utilized a qualitative lens which delivered a more in-depth representation of the lived experiences of rural Haitian women experiencing poor health as it relates to the lack of access to health care services. The focus of these studies was largely on the various challenges Haitian people face to access and utilize health care services; yet, researchers focused less on rural area population of women who lack access to health care services through the barriers within their environments.

Poverty is a well-studied and well-documented phenomenon. Various angles on poverty such as sociological, educational, and economic angles are well-researched. Similarly, for many unindustrialized countries, data on the vital undertakings of Haiti's

population has been limited. Thus far, very few studies have focused on the lived experiences of poor women in rural Haiti who have poorer health outcomes as a result of poverty. This literature confirmed an apparent connection between poverty and health, particularly in rural Haiti, as poorer people are at a higher predisposition to acquiring illnesses and lack access to medical care once an actual illness is acquired. While various studies supported the relationship between poverty and poor health, I found a significant gap in the research literature. To address this gap, I explored the connection between poverty and lack of access to health services that led to poorer health among rural Haiti women, emphasizing socioeconomic factors attributable to poverty such as educational level and employment status.

For this research concentrating on Haiti poverty and its impacts on the health of rural Haitian women, findings about poverty factors and their influences on Haitian women's health status and access to health care services could advocate for positive social change strategies and efforts both at the individual and institutional level to improve public health conditions, for the Haitian society as a whole particularly for Haitian women living in poverty. Therefore, I conducted this study to focus on efforts and real-world applications to increase access to health care services to generate positive social change implications. In the next chapter, I explained, justified, and finalized the research methodology, and designed a plan that facilitated answering the research questions concerning poverty and its impact on health outcomes, as experienced by poor women living in rural Haiti.

Chapter 3: Research Method

Introduction

This chapter includes the exact steps that I carried out to address the research questions of this study. A qualitative phenomenological method of inquiry was used to answer the central research question: What role does poverty play in the poor health of women in rural Haiti? From this overarching research question, two subquestions were derived: What are the lived experience of Haitian women in poverty and its impact on access to health care services? How do socioeconomic factors such as lack of employment and educational resources impact the health status of poor Haitian women living in rural Haiti?

The purpose of this exploratory qualitative study was to cultivate a greater understanding of the factors that impact access to health care services that ultimately affect the health status of poor rural Haitian women. A phenomenological approach was used to provide a detailed understanding of the lived poverty experiences, social factors, behaviors, beliefs, and values that contributed to participants' health status (Adams & van Manen, 2008; Patton, 2015). This chapter provides an in-depth overview of the chosen research methodology and research design, covering various subtopics such as study participant selection, sampling, and recruitment strategies, as well as data collection instrumentation, procedures, analysis, and interpretations. Finally, I have provided an overview of the credibility of the study, the ethical procedures, and a chapter summary that recapitulated the main points.

Research Design and Rationale

A qualitative phenomenological approach was the research methodology selected for this study. This research approach provided an opportunity for study participants to talk about their lived experiences and offered insights into their decisions, behaviors, and motivations (Embree, 1997; Moustakas, 2004). It provided a greater exploration and understanding of poverty experiences and the social factors, behaviors, beliefs, and values that influenced participants' health status using individual structured interviews. Using a qualitative phenomenological design to study the in-depth experiences and stories of each participants helped me achieve a deeper understanding and meaning of the specific phenomenon that was examined in this study: poverty among rural Haitian women and how it impacts their health. Structuring meaning in phenomenological design helped describe and clarify the subjective experiences of the study participants (Adams & van Manen, 2008; Moustakas, 2004).

Collected data compared experiences and stories for word phrases or concepts that matched the codes and categories (Gibbs & Taylor, 2005) of socioeconomic status, educational attainment, and employment status. Ultimately, the qualitative phenomenological design is a tool used to attain a profound understanding of the poverty phenomenon (Creswell, 2009, 2013). I did not choose a quantitative design for this research study because of my desire to explore an in-depth understanding of each participant's lived experiences with poverty, which is impossible to capture through the testing of variables and statistical data analysis (Creswell, 2009, 2013; Patton, 2015; Tracy, 2010). A qualitative design is an inductive data collection method that guided the

course of the study, which is different from a quantitative design, enabling a deductive process using a hypothesis from a preexistent theory (Creswell, 2009, 2013).

The qualitative design uses five different approaches including case study, ethnography, grounded theory, phenomenology, and narrative research to discover, describe, and understand a person's complex social environment (Creswell, 2013). Exploring different qualitative designs was important in helping me determined the relevance of each method to my research questions. Accordingly, among the five qualitative designs, I selected phenomenology because my focus was on exploring and describing what all individuals have in common as they experience a phenomenon, in this case, poverty; the description consisted of what they experienced and how they experienced it (Embree, 1997; Moustakas, 2004). With regard to methodology, Trochim (2001) emphasized that "A qualitative phenomenological investigation was emphasized as a school of thought that focused on people's subjective and reflective experiences and interactions with their environment and people in that environment" (pp. 159-160). For that reason, I chose the phenomenology qualitative method because its primary focus is on the meaning people attributed to their lived experiences (Adams & van Manen, 2008; Trochim, 2001).

Research Tradition and Rationale for Chosen Tradition

When I selected the qualitative method, I did not chose an ethnography approach because data are collected through prolonged observations of a group of people so that the researcher can fully immerse in their lives and daily routine in an attempt to understand the meaning behind their values, beliefs, behaviors, dialect used, and the way

they interact among themselves (Creswell, 2013; Frambach, van der Vleuten, & Durning, 2013; Patton, 2015). A researcher who uses this approach seeks to observe people for a prolonged period, and my phenomenological study did not require this type of extended enculturation with the study population. I did not selected a case study or narrative approach because these approaches explore an issue or a process using a single case as a specific illustration to develop a profound understanding of present-day setting, and I used more than one participant for my research study (Creswell, 2013; F. E. Moore, 2010). A grounded theory approach was not selected for my research because grounded theory are derived from data as opposed to preexisting theory (Creswell, 2009; Merriam, 2009).

For my research, a preexisting theory known as SEM was used as the foundation for the data analysis process by showing how different environmental constructs influence health outcomes and provide an explanation to understanding the intrapersonal, interpersonal, organizational, community, and public policy factors that influence health outcomes of poor women living in rural Haiti (Glanz et al., 2008; Onwuegbuzie, Collins, & Frels, 2013). This theory also assisted me in sorting collected data into categories, codes, and emergent themes connecting each participant's unique experiences with poverty. On account of the unsuitability of the previously mentioned qualitative approaches, I chose phenomenology as the most suitable research approach because it centered on lived experiences of a particular phenomenon and is used as a guide to condense different individual experiences into one essential concept. Therefore, this approach fits with my research purpose: to seek answers through the way others viewed

and lived their lives. Given this research design, it is imperative to comprehend and recognize my role as a researcher in confirming awareness of any personal and ethical challenges that influenced this study. Thus, in the next section, I provided a detailed discussion of my role as a researcher.

Role of the Researcher

As a qualitative researcher, I hoped to explore and understand the views of the lived experiences of each participant living in poverty and how it influenced their health status using individual structured interviews. Indeed, a qualitative phenomenological design allowed a glimpse into a participant's thoughts and perspectives to discover, describe, and interpret the rich meaning of their subjective experiences (Creswell, 2013).

Personal and Ethical Biases

I was born and raised in the urban Artibonite region, Gonaives, Haiti, and had experienced the culture and norms of the region, including the direst of poverty. In the 1990s, I attended middle school in Haiti and had a good understanding of both official languages of the country. Based on my literature review, more than 57% of the households in rural regions lived in absolute poverty, especially in the northwestern and northeastern regions of Haiti (Gage & Calixte, 2006). For that reason, I conducted my study primarily in the Northwest Artibonite regions of Haiti. I divided my data collection process between two poor rural areas within the Artibonite region: Au Poteau (six participants) and Fonds Cheval (six participants). I was aware that this prior experience and understanding of the Haitian culture and language might have constituted personal biases to the study. However, during the data interpretation process, I utilized my

understanding and interpretation of the data collected. Assumed knowledge and inappropriate interpretation can be problematic at times, as they tend to prevent adequate clarification from the participants (Chenail, 2011). For that reason, I reduced the risks of being biased by using bracketing and including reliable academic resources, examples, and references that supported every aspect of this study, especially data interpretation.

Ethical Issues

Using incentive was an ethical issue considered during the research study process because I used monetary incentive (Haitian Gourdes 250) as a means of thanking participants for their time. Haitian Gourdes 250 is equivalent to approximately US$3.862 (CoinMill, 2016). Providing an incentive of less than US$5 at the conclusion of the interview to thank participants for their time was an appropriate amount without being so significant that it could be perceived as coercive (Clarke, 2006). Because individuals living in rural Haiti had lower educational background, research materials explained the purpose of research activities without making cultural, social, and educational assumptions (Walden University, 2015). In addition to English, all informed consent forms were also in Creole, the local dialect used in the part of Haiti where I conducted my study. I started with English written at about a 6th grade level, and then I translated it into the Creole language at much simpler than 6th grade level.

Methodology

Given that phenomenology was the chosen methodology for this study, I incorporated several strategies that were relevant to the chosen research design including participant selection, sampling, and recruitment, as well as data collection and data

analysis. The strategies were used as the foundation for collecting the in-depth data and explored the lived experiences of rural Haitian women living in poverty and how it impacts their health status.

Participant Selection

The criteria for selecting participants for this study was the poorest group of rural people in Haiti. These included women 18 years old and older who self-identified as (a) heads of households, (b) housewives confined to traditional roles and activities, (c) domestic servants, (d) charcoal producers/vendors, and (e) rural agricultural workers, farmers, and sharecroppers. Another criterion for selecting study participants included women in rural areas who did not have easy access to health care services, as health care centers, free public clinics, and hospitals were not easily found in the villages. The identity of each participant remained confidential as I used pseudonyms. This standard was also used to maintain the principle of beneficence for the participants (Walden University, 2015); consequently, it helped me interpret their stories and lived experiences effectively and maintained that human element.

Sampling Plan

I used a purposeful homogenous sampling with a sample size of 12 rural Haitian women living in poverty who shared the same characteristics such as similar lived experiences and socioeconomic backgrounds. Participant selection in purposeful homogenous sampling is based on the purpose of the research, emphasizing participants with shared characteristics and similar experiences (Coyne, 2007; Marshall, 2006; Palinkas et al., 2013). For instance, selected participants in purposeful homogenous

sampling would have similar life experiences, culture, gender, and backgrounds (Coyne, 2007; Marshall, 2006; Palinkas et al., 2013). The objective of purposeful homogenous sampling is for researchers to select and focus on particular people with specific and consistent similarities to support with the purpose of the research (Coyne, 2007; Marshall, 2006; Palinkas et al., 2013). The sampling strategy must be appropriate for the primary research question, the purpose and the limitations of the study, and the resources available (Patton, 2015). Therefore, for this qualitative research focusing on exploring to what extent poverty affects the health of rural Haitian women, I used a purposeful homogenous sampling with a sample size of 12 women who shared the same characteristics, life experiences, and socioeconomic backgrounds, exploring to what extent poverty negatively influenced their health outcome and health status. This sample was used to find shared poverty experiences, situations, and characteristics.

Because qualitative studies deliberately seek knowledgeable participants who can contribute significantly to enriching the understanding of a phenomenon (Rudestam & Newton, 2015), purposeful sampling was used to identify participants with common poverty characteristics and circumstances and explored to what extent poverty negatively influenced their health and health status. Most phenomenological studies engage a relatively small number of participants (10 or fewer) (Moustakas, 1994, 2004). However, in the quest for data saturation, I included two additional participants other than the recommended number of participants (10 or fewer). A small sample size ($N = 12$) offered me the best opportunity to reach data saturation (Bowen, 2008; Burmeister & Aitken, 2012; Fusch & Ness, 2015; Onwuegbuzie, Leech, & Collins, 2010). In the results section,

I discussed the details of how the data reached data saturation (Walker, 2012). The sample size used will give readers enough information to be able to carry out similar research themselves (Porte, 2013; Rudestam & Newton, 2015).

Recruitment Process

To recruit participants, I worked in partnership with a trusted village leader that introduced me to the villagers. Once the introduction occurred, I explained the study and asked individuals to participate. This cooperating individual was also my guide in navigating the rural regions and local structures to identify eligible participants. The village leader was not present when I explained the study and asked individuals to participate. A letter of cooperation was not applicable for my study as it can only be used to document organizational approval. There was no organization assisting in the study. In recruiting the initial participants, the village leader introduced me to two to three women who fit the study criteria. After the introduction had been made, I confirmed that each participant met the eligibility requirements for the study, I explained the purpose of the study to each participant, and asked them to participate. Then, I acquired their contact information and arranged a meeting time and location to conduct the interview. Another recruiting strategy used was the snowball sampling by asking participants to introduce other potential participants to the study by spreading the word around to their friends, neighbors, and family members who also met the eligibility requirements and desired to participate in the study.

Instrumentation

Data Collection

The data collection instrument I used for this qualitative phenomenological study was semistructured interviews with each participant focusing on capturing their lived experiences (Cairney & St Denny, 2015; Warren, 2002). "The phenomenological interview involves an informal interactive process aimed at evoking a comprehensive account of the person's experience of the phenomenon" (Moustakas, 1994, p. 114). Researchers commonly utilized the interview, one of the most popular and flexible methods to collect and gain qualitative data about people's feelings, views, and experiences (Cairney & St Denny, 2015; Warren, 2002). An interview is regarded as a guided conversation between a researcher and a study participant to evoke descriptions of lived-through moments, remembered stories of particular experiences, and experiential anecdotal accounts (Cairney & St Denny, 2015; Warren, 2002). According to Adams and van Manen (2008), capturing a personal description of a lived experience help a researcher describes the phenomenon as much as possible in concrete and lived-though terms (p. 618). Interviews, as a data collection approach, have been used in the past to demonstrate just how data saturation had been reached (Porte, 2013). During the data collection process, I conducted the interviews in a way that helped me reach data saturation by gathering data that were rich and thick (Bunce & Johnson, 2006; Cairney & St Denny, 2015; Warren, 2002).

The interview consisted of questions from the semistructured interview guide and lasted about 25 to 45 minutes for each participant. At the beginning of every interview, I

provided an overview of the study and an explained the consent form before the participants signed it. I conducted the interviews at a location of the participant's choice, including their home. I audiotaped all the interviews on a tape recorder and transcribed them. At the conclusion of each interview, I gave each participant an opportunity to ask questions in regards to the research study and I provided them a monetary incentive of 250 Haitian Gourdes (US$3.86) to thank them for their time. I also asked participants for their permission to be contacted for follow-up interviews that were necessary during the data collection process. I took another trip back to each villages respectively to follow-up with each participants utilizing member-checking techniques by asking additional questions to ensure trustworthiness of the data.

Intensive Interviewing

For my interviews, I utilized a semistructured interview guide based on the poverty literature to generate discussion surrounding the major research questions for the study. The guide was semistructured and guided by open-ended questions. The initial interview questions focused on problem recognition or poverty experiences in rural Haiti (i.e., "Would you describe yourself as poor? If yes, why?"). The intermediate questions focused on rural poverty influence on access to health care services and health status (i.e., "What do you do when you or one of your family members gets sick?"). The final questions focused on rural poverty influences on socioeconomic status (i.e. "How does being poor affect your quality of life?"). Using intensive interviewing was beneficial as a data collection instrument because it helped in answering the research questions and increased the range or scope of data exposed to uncover a full array of perspectives from

the sample participants (Cairney & St Denny, 2015; Warren, 2002). The semistructured interview guide is located in Appendix A.

Data Analysis Plan

Once all interview data and field notes were translated and transcribed in its entirety, the process of qualitative data analysis began. The data was managed by creating and organizing data files and saving backup copies using carefully chosen software (Creswell, 2013). Analyzing and interpreting the data was completed by thorough reading while making marginal notes (memoing) and forming the basis for the initial codes (Patton, 2015). At this point, a digital framework was constructed by clearly arranging the transcripts into question responses. The transcripts were coded and organized into themes according to concepts and experiences relating to poverty and its impact on health. During the data analysis, the process of horizontalization took place by evaluating each statement at equal value (Moustakas, 1994). The data analysis used Moustakas's (1994) modified van Kaam seven steps method for phenomenological analysis. This analysis method helped me to achieve a greater understanding of rural women experiences with poverty. I provided a presentation of the Moustakas's modified van Kaam method for phenomenological analysis below.

The first step was the preliminary grouping and listing together all statements and phrases gathered from participants' experiences, which were relevant to the research questions (Moustakas, 1994). This process involved recording all statements of relevance to the poverty phenomenon. The second step involved reduction and elimination of all the insignificant data that were collected from the first step (Moustakas, 1994). In this step, I

threw out vague and duplicate comments. The third step involved the clustering of major themes by reviewing invariant constituents that were developed in the two previous steps (Moustakas, 1994), meaning that I identified and clustered together any constituents that expressed commonality in addressing the poverty phenomenon to reveal major themes. The fourth step involved the final identification of the invariant constituents and themes, which was determined by comparing the clusters of invariant constituents developed in the previous steps to ensure that I properly labeled and analyzed all data (Moustakas, 1994). In other word, I removed any data that was incompatible with the identified major themes from the analysis.

Step 5 in Moustakas's modified van Kaam seven steps method for phenomenological analysis involved the construction of individual textural descriptions based on the final invariant constituents and developed themes (Moustakas, 1994). These descriptions took into account the verbatim responses for each participant relevant to the research questions. Step 6 involved constructing a structural description from my interpretation (Moustakas, 1994). The seventh or final step involved constructing individual textural and structural descriptions of each participant's experience, merging both verbatim responses of the participants and the imaginative variation to demonstrate the meanings and essences of the experience in a comprehensible and understandable narrative for the entire sample (Moustakas, 1994). Because the process, procedures, and duration of analysis varied depending on unforeseen events, I reported a more thorough discussion of analytical procedures, problems, and limitations in Chapter 4. To develop a trustworthy study, I had to consider the issues of trustworthiness in a study. The next

section of this chapter discussed the issues of trustworthiness, an essential aspect of research methods implementation.

Issues of Trustworthiness

To ensure trustworthiness in this research study, I combined various strategies including credibility, transferability, reliability, and objectivity (Krefting, 1991). To confirmed credibility and dependability, I used triangulation, an effective process that supported data validation using a cross verification from two or more sources (Bekhet & Zauszniewski, 2012; Gorissen, van Bruggen, & Jochems, 2013; Malterud, 2001; Wray, Markovic, & Manderson, 2007). During the initial phase of the data analysis process, I triangulated data to two people on my research team, my methodologist and content expert, to facilitate data validation; then, I incorporated and applied their feedbacks to the remaining analysis process. Another strategy I used to confirmed credibility was data saturation, a method used to ensure that sufficient, and quality data were collected to support the research (Morse, Lowery, & Steury, 2014; O'Reilly & Parker, 2012). During the data collection and analysis stage, I collected and analyzed data to the point where no new insights, themes, concepts, and findings were detected in the data. In chapter 4, I provided further elaboration of what my data saturation entailed and how it was achieved in the context of the study and the collected data. To ensure reliability, I tape recorded and transcribed all the interviews.

To ensure transferability, I provided a thick, in-depth description of the participants and variation in participant selection (Barbour, 2001; Meyrick, 2006). Moreover, I described any relevant data related to the SEM theoretical framework to

ensure that the same results and findings can be replicated in another qualitative study in a social context. I also enhanced transferability in this research study by thoroughly described the central research concepts and assumptions (Barbour, 2001; Meyrick, 2006). There are several strategies to help enhance confirmability, the degree to which the results of a study could be corroborated and confirmed by other people (Patton, 2015; Rudestam & Newton, 2015). To established confirmability, I used a journal to document all the measures taking for checking and rechecking the data during the study. After the study, I conducted a data audit to inspect the data collection and analysis processes to ensure that the participants shaped the findings and not my personal bias, motivation, and interest (Chenail, 2011). Trustworthiness of a research study is important to evaluate its worth, resonate with readers, provide meaningful coherence, and ultimately make an original significant contribution to the field (Gordon & Patterson, 2013; Shenton, 2004). In the next section, I will discussed the ethical procedures, another important concept in the study.

Ethical Procedures

As a researcher, one of my principal responsibilities was to continually conduct myself in an ethical manner which included having Walden University's Institutional Review Board (IRB) review my research before data collection for its adherence to ethical standards and to guarantee that informed consent was obtained before initiating the research. Walden University's IRB approval number for this study was 01-27-17-0447000 (Appendix E). Based on Walden University (2015) Research Ethics & Compliance Guides for the IRB application, economically disadvantaged people are

considered a vulnerable group. The participants for my research study are poor rural Haitian women living in direst poverty, which fit the vulnerable category of economically disadvantaged people. Accordingly, the IRB process ensured that my research study procedures protected the participants by developing an informed consent particularly tailored for this vulnerable group (Walden University, 2015). Moreover, because the participants (poor women in rural Haiti) had different social and educational background, IRB research procedures strongly advised measures that were followed to maintain participant's right and confidentiality (Walden University, 2015). These included safety and privacy risks, screening procedures, voluntary participation as well as study materials explaining the purpose of research activities without making cultural, social, and educational assumptions (Walden University, 2015).

For the screening procedures, I created survey questions outlining clear and specific details concerning my study so that all participants had necessary details in advance to assess their eligibility and ability to participate in my research study. Participants were not forced or coerced to participate, and this standard included not giving them a significant amount of money as incentive. At the conclusion of the interview, each participant received 250 Haitian Gourde (equivalent to US$3.86). An incentive of less than US$5 was an appropriate amount devoid of coercion.

Participation was voluntary and all participants were required to read and sign a consent form before beginning the interview and they were not allowed to proceed without reading and signing the consent form. I ensured that the interviews were conducted in a confidential location where no one else was present during the interview.

Furthermore, each participant received in-depth disclosure of the risks and benefits, along with complete details of the study for them to decide and determine whether or not to participate in the study. All informed consent form and protocol were prepared in English but translated into the language in which the participants are fluent (Haitian Creole). An interpreter was not required as I am fluent in the language and dialect in which the participants are fluent.

As the researcher, I was also familiar enough with the culture to authentically understood local norms of privacy, confidentiality, and advocacy. The IRB sought the assurance that I was sufficiently accustomed to the culture to authentically comprehend local norms of privacy, confidentiality, and advocacy (U.S. Department of Health and Human Services [HHS], 2000; Walden University, 2015). It was important for me to be fluent in the dialects or languages in which the participants were fluent, and prepared and obtained consent documents in the official language of the country. IRB only approves protocols in which informed consent can occur in a language or dialect in which the participants are fluent for studies outside of the United States (HHS, 2000; Walden University, 2015)). I provided each participants a written copy of the informed consent form to keep. In agreeing to participate, the participants were under no obligation to answered questions or shared personal information that made them feel uncomfortable. For instance, if a question triggered recollection of painful memories, the participants were able to withdraw from the study at any time without consequences. At the end of the interview, participants had an opportunity to review my notes and asked to modify or remove any portion that they did not agree with. All of the interviews were tape-recorded,

but no one was identified by name on the tape. I informed participants that the collected data would only be shared with my research committee; I also included this information on the consent form. Another safety and privacy procedure included storing audio and written data files in a safe location for up to 5 years. After 5 years, I will destroyed all stored data.

Additional steps were taken to guarantee the protection of the participants. Before attaining IRB approval to interview human participants, it was mandatory to take and pass the Human Research Protections training for doing research with human participants. This test assessed my knowledge of responsibilities, rights, and ethical standards for conducting research, working with, and interviewing human beings. According to HHS (2000), when conducting research involving human subjects in a foreign country, a researcher must adhere to the highest international ethical standards and consult the international compilation of regulations provided by the USA Federal Office for Human Research Protections (OHRP) to familiarize with regulations, government infrastructures, and guidelines that are relevant to human subjects' research, organized by country (para. 5).

Chapter 3 Summary

To understand to what extent the rural poverty phenomenon in Haiti particularly impacts the health status of women, I used a qualitative phenomenological research methodology to carry out this study. I chose a qualitative phenomenological research approach because it provided an opportunity for study participants to talk about their lived experiences with poverty and gave insights into the impact, their decisions,

behaviors, and motivations as a result of living in poverty. Also, a phenomenological approach enabled me to collect the stories and lived experiences of each participant and provided a greater exploration and understanding of the poverty phenomenon, a social factor that influenced participants' health status. This chapter included a detailed descriptions of the study's research questions, the role of the researcher, the chosen research design, study participants, recruitment plan, and sampling plan. This chapter also included an in-depth description of the study's ethical procedures to ensure the protection of the participants along with addressing the evaluation criteria to support the trustworthiness of the study. Chapter 4 included a complete and extensive presentation of the study results summarizing the collected data and its analysis.

Chapter 4: Results

Introduction

The purpose of this phenomenological qualitative study was to develop a greater understanding of the factors that impact access to health care services that ultimately affect the overall health of poor women living in rural Haiti. The central research question for this study was: What role does poverty play in the poor health of women in rural Haiti? From this, two subquestions were derived: What are the lived experiences of Haitian women in poverty and its impact on access to health care services? How do socioeconomic factors such as lack of employment and educational resources impact the health status of poor Haitian women living in rural Haiti? The research question explored potential connections between poverty and poor health among women in rural Haiti as it related to health status and access to health care services. The social change implication for this study could help develop new programs for women in rural areas to improve more access to health care services that will positively influence their health outcome and health status.

Chapter 4 started with a brief introduction of the purpose of the study and the research question. It described the setting of the study and participant demographics relevant to the data. This chapter provided details about the data collection and data analysis process and presented evidence of trustworthiness, in addition to addressing the findings and results found throughout the data analysis. The chapter concluded with a summary that recapitulated answers to the research questions and provided a transition to Chapter 5.

Setting and Demographics

There were no personal or organizational conditions that influenced participants or their experiences at the time of study that affected the interpretation of the study results. The study sample included 12 poor Haitian women, 18 and older, living in rural villages of the Northwest Artibonite regions of Haiti, experiencing poverty, and lacking access to basic health care services. Although the sample shared similarities living in rural regions, I divided my data collection between two poor rural areas within the Artibonite region: Au Poteau (6 participants) and Fonds Cheval (6 participants). The sample reflected a difference in age, which ranged from 18 to 65. All participants were native of Haiti's rural regions and spoke the Creole language fluently.

The self-reported levels of education were as follows: eight participants had no education or illiterate, and four had attempted primary school. Eight of the participants reported that they were unemployed, one was a farmer, two were charcoal producers and vendor, and one was a domestic servant. Eight of the participants were single mothers, three were widowed, and one was married. Nine of the participants had between five to seven people in their household and made less than $1,000 HTG (US$12) a month. Half of the participants reported that they had zero access to health care centers or clinics in the area or village where they lived. The other half had access to only one clinic in the area where they lived. Six participants reported that the clinic was more than 1 hour away and six reported that the clinic was less than 1 hour away from where they lived. All 12 participants used walking as the main form of transportation.

Table 1

Participants Demographic

Participants	Age	Education	Employment	Income	Marital Status	# of Clinics	Clinic Distance	# of children or dependents
P1	30	No Education	No Employment	Less than 1000 HTG ($US12) per month	Widow	0	More than 1 hour away (walking)	3
P2	32	No Education	No Employment	Less than 1000 HTG ($US12 per month	Single	0	More than 1 hour away (walking)	5
P3	45	No Education	No Employment	Less than 1000 HTG ($US12) per month	Single	0	More than 1 hour away (walking)	4
P4	65	No Education	No Employment	Less than 1000 HTG ($US12) Per month	Widow	0	More than 1 hour away (walking)	Two grown kids
P5	47	No Education	Farmer	About 1000 HTG ($US12) per month	Separated	0	More than 1 hour away (walking)	5
P6	30	Completed some primary school	Charcoal Vendor	About 1000 HTG ($US12 per month)	Married	0	More than 1 hour away (walking)	3
P7	22	Completed some primary school	No Employment	Less than 1000 HTG ($US12) per month	Single	1	Less than 1 hour away (walking)	1
P8	26	No Education	Domestic Servant	About 1000 HTG ($US12) Per month	Single	1	Less than 1 hour away (walking)	4
P9	18	Completed some primary school	No Employment	Less than 1000 HTG ($US12) per month	Single	1	Less than 1 hour away (walking)	2
P10	37	No Education	Charcoal Vendor	About 1000 HTG ($US12) Per month	Separated	1	Less than 1 hour away (walking)	4
P11	35	No Education	Farmer	1000 HTG ($US12) per month	Single	1	Walk less than 1 hour	5

(table continues)

Participants	Age	Education	Employment	Income	Marital Status	# of Clinics	Clinic Distance	# of children or dependents
P12	32	No Education	No Employment	1000 HTG ($US12) per month	Single	1	Less than 1 hour away (walking)	6

Data Collection

Data collection employed individual semistructured interviews with participants for approximately a half hour using open-ended, in-depth questions. I used an interview worksheet comprising of 10 interview questions and probes (Appendix A) as a guide to provide consistency with the interviews. I also used 13 demographic survey questions (Appendix B) for data collection. The responses to the questions provided background information about the participants' experiences with poverty as it related to their health and access to health care services. Participants included 12 poor rural Haitian women 18 years and older who self-identified as (a) heads of households, (b) housewives confined to traditional roles and activities, (c) domestic servants, (d) charcoal producers/vendors, and (e) rural agricultural workers, farmers, and sharecroppers. The study also involved women in rural areas who did not have easy access to health care services. After I read and explained the contents of the consent form, all 12 participants agreed to participate and signed the informed consent form using different identifying letters such as initials and crosses and granted permission for digital audio tape recording to take place. Four participants who completed some primary school were able to sign their full signature and used their initials as a signature. The remaining eight used the letter X as a replacement for an individual's signature because they were completely illiterate and did not know how to write.

I started out all the interviews explaining the purpose and nature of the study, and I encouraged participants to ask any questions they had before they decided to participate. Each participant received the demographic survey questions and the 10 open-ended interview questions. All 12 interviews took place in person at the participant's home. The semistructured conversational interviews lasted between 20 and 30 minutes except for the first one that only lasted 12 minutes. The participants' transcribed interviews provided information on the way poverty affected access to health care and health status of women living in rural Haiti. Upon successful completion of the interviews, I immediately transferred the 12 separate digital recordings of the raw data to my computer, saved them, and made a copy on a password-protected disk, therefore protecting the confidentiality of the participants. The interviews took about 60 hours to translate and transcribe. The transcribed text resulted in approximately 41 pages of data, which were reduced to categories, codes, patterns, and emergent themes. The transcriptions excluded remote and repetitive data that were not related to the description of the phenomenon.

Data Analysis

The data analysis was based on Moustakas's (1994) modified van Kaam seven steps method for phenomenological analysis, as described in Chapter 3. This analysis method helped me to achieve a greater understanding of rural women's experiences with the poverty phenomenon. Analyzing the essence of the participants' experiences was one of the main elements in the modified van Kaam seven steps method for phenomenological analysis (Moustakas, 1994).

I examined and analyzed the data as experiences from each woman because they each had unique stories and experiences to share. Codes were applied to the interview transcripts to organize the data succinctly. I developed themes from the codes that applied to the research questions and theoretical framework concepts. Using the epoché method was pertinent in helping me to withhold all judgment, conclusion, and preconceived ideas when collecting and examining the data (Moustakas, 1994). According to Patton (2015), the epoché method offered mindfulness of any assumptions, viewpoints, or prejudices about the way poverty impacted health (p. 536). As a result, researchers are more aware of the emerging themes, hence giving emphasis to the phenomenon and the lived experiences of the participants (Moustakas, 1994). I also used daily meditation and scripture reading strategies to bracket out potential preconceptions or assumptions that may have tainted the research process (Patton, 2015).

Coding Procedure

After I transcribed the interviews, I started the process of qualitative data analysis immediately. I managed the data by creating and organizing data files and saving backup copies using carefully chosen software (Creswell, 2013). Analyzing and interpreting the data was completed by thorough reading while making marginal notes (memoing) and forming the basis for the initial codes (Patton, 2015). At this point, I constructed a digital framework by clearly arranging the transcripts into question responses. I coded and organized the transcripts into themes according to concepts or experiences relating to poverty and its impact on health. During the data analysis, the process of horizontalization took place when I evaluated each statement at equal value (Moustakas,

1994). During this imaginative variation process, I considered universal structures for generated feelings and thoughts regarding poverty (Moustakas, 1994). In the classification process, I analyzed the data by looking for common and reoccurring themes, patterned regularities, repeated words, phrases, stories, beliefs, events. Then, the data were coded and organized into (a) research question meanings, (b) roles and actions, (c) nodes, and (d) example categories. All these groupings were connected and distilled into categories, which allowed patterns to emerge as themes (Creswell, 2013). A codebook was developed to ensure consistent coding throughout the analysis process (Appendix C).

Evidence of Trustworthiness

To ensure credibility I used saturation, a process used to make sure that quality and adequate data were gathered to support the research (Morse et al., 2014; O'Reilly & Parker, 2012). All through the data collection and analysis process, I collected and analyzed the data to the point where no new concepts, themes, findings, and insights were evident or detected in the data (Morse et al., 2014; O'Reilly & Parker, 2012). To ensure transferability, I used audio recording and transcription (Santiago-Delefosse, Gavin, Bruchez, Roux & Stephen, 2016). I audio recorded each interview with a digital audio recorder. These individual interviews were later transcribed verbatim with coding to preserve anonymity.

During the initial phase of the data collection process, I did not triangulate data with my dissertation team. However, I used the analyst triangulation technique during the initial stage of the data analysis process to ensure that data were rich, robust,

comprehensive, and well-developed to illuminate blind spots in the analysis (Bekhet & Zauszniewski, 2012; Varpio, Ajjawi, Monrouxe, O'brien & Rees, 2017). In this light, I incorporated and applied feedback from the content expert and methodologist and consulted with her frequently during the analysis process in facilitating data validation. The dissertation methodologist and I reviewed the coding, categories, and findings after I completed and coded all of the interviews. I applied all feedback from the methodologist to my transcription data and analysis process. Member-checking was included as another strategy used to ensure the trustworthiness of the study. I took another trip back to each village respectively to follow-up with each participant utilizing member-checking techniques and asking additional questions (Patton, 2015). I sat down with them again to review and read the transcribed analysis of the data collected from them and received confirmation that my analysis was accurate. The member-checking procedure increased the validity of the study (Creswell, 2013; Patton, 2015). My review with each participant was based on the main categories and themes generated from the data. Generative themes and experiences arising from the data were constructed and analyzed for insights, possibilities, and actions.

Notes from my journal were used to document thoughts and add context to some of the local expressions and essences of the situations. As far as my researcher bias was concerned, it was important to note that I am a Haitian woman. I am of the same race as the participants, but I am not related to any of the participants or anyone living in the rural regions where the study was conducted. During the interview process, I did my best not to bias the results or encouraged the participants to give me the answers that I

anticipated. The topic, poverty, was a difficult topic to ask and listen to answers with as little emotion as possible. I did stop the participants on several occasions to make sure they wanted and were able to continue.

To establish confirmability, I utilized a notebook to keep track of all the procedures involved in checking and rechecking the data. To ensure credibility, I also created an audit trail of the research process to check the data collection and analysis procedures ensuring that the results were molded only by the participants and not by personal motivation, bias, and anticipation. My audit trail consisted of dates and times I conducted interviews, transcribed interviews, in addition to, documented field notes (Appendix D). In the next section, I presented data to support the results of the study.

Results

This study included one overarching research question that provided the structure for guiding the study: What role does poverty play in the poor health of women in rural Haiti? From this, two subquestions were derived:

1. What are the lived experiences of Haitian women in poverty and its impact on access to health care services?
2. How do socioeconomic factors such as lack of employment and educational resources impact the health status of poor Haitian women living in rural Haiti?

The essence and experience of the impact of poverty on health were brought to more clarity through a 10 questions worksheet that expanded on the research questions (Appendix A). The data are supported by deeply descriptive and intimate statements that reveal the essence of experiencing poverty. Responses from participants described what

all participants had in common as they experienced the poverty phenomenon, this description consisted of what they experienced and how they experienced it. Interview questions related to poverty and its impacts on access to health services generated two themes: (a) barriers to health care; and (b) alternatives to health care. Interview questions related to socioeconomic status and its impacts on health generated the other two themes: (c) living conditions; and (d) effects of no health care.

Emerging Themes

The recorded data were listened to, transcribed, and read multiple times. I also highlighted relevant words and phrases in the transcripts. The interview transcripts were reviewed once more, and all the important words were compiled into a coding list of 34 codes and arranged and grouped into four different themes. The coding words, phrases, and sentences created an expanded and detailed codebook (Appendix C). After I read and reread each of the coded groupings, descriptive statements were clarified and written to help explained and revealed the essence of the impact of poverty on health. This process was accomplished by developing an explanation of the reoccurring and most repeated thoughts. The methodologist on my dissertation team reviewed the transcripts to verify that the codes and themes were identified appropriately.

The four themes that emerged from the study data are mentioned below, along with the supporting statements for each theme describing the lived experiences of rural Haitian women living in poverty and the way the poverty phenomenon impacted their health and access to health care services. After narrowing down the total number of themes following a more thorough research review, I examined the same data comparing

each section to other sections by comparing responses and codes from one section to responses and codes from the other sections, which helped in generating the following reoccurring four themes and their corresponding codes.

- Living conditions – include food, money, low socioeconomic status, and living conditions
- Barriers to health care – include transportation, lack services, neglect health care
- Alternatives to health care – include alternative medicine, spirituality
- Effects of no care – include chronic stress, chronic illnesses, teenage pregnancy, infant mortality

Theme 1: Living Conditions

The living condition theme includes factors such as lack of food, money, low socioeconomic status, and poor living conditions. The first code identified by all participants was the lack of food and food resources that negatively affected their health. The participants' responses (12 out of 12) revealed that they were almost always lacking in food and had poor nutrition experiences, which decreased their bodies' ability to fight diseases that led to many other health issues as well. Participants' responses were overwhelmingly powerful about the impact lack of food has had on their wellbeing and overall health. Low socioeconomic status and lack of money were other major reoccurring concepts in the living condition theme category. All of the participants were living in dire poverty and could not afford basic survival necessities or health services to

treat or alleviate illnesses. The following were some of the responses that captured the essence of this theme:

Lack of food. Malnutrition, starvation, undernourishment, hunger, and emaciation were among the common codes under the disadvantaged living conditions theme. All of the participants expressed the need for not having food to eat, an essential part of one's daily lives to maintain good health. All of the participants were devastatingly impacted by the lack of food resources and availability of food in the area where they lived. Lack of food has had a negative impact on their daily lives, as well as their health. The following were some of the responses that captured the essence of these codes:

> (P1) Sometimes, I find nothing to cook for my family and I have no money to go out to the market to buy things to cook; so my family and I drink water with a dash of salt, and we go to bed.
>
> (P3) Some days, my kids and I do not eat because I have nothing in the house to feed us and I have no money to buy food. We stay like that.
>
> (P6) Sometimes I can't even afford breakfast to give them, especially the one who needs more strength to walk 3 hours to school. Some days, he walked 3 hours back home from school and didn't find anything to eat because I don't have anything around the house to give him or the other two kids that stayed home with me. They would cry and cry because they are hungry, but there is nothing I can do about it because I don't have food or money to buy it.

(P2) If my partner doesn't have any money to give me, the whole family stay hungry for days until he gives me something.

(P4) I get dizzy when I spent a long period without putting something in my stomach. I can't see straight; I can't stand at all until I eat something. I don't have any money to buy food for myself; I have to wait to see if my friend is cooking so she can share a little bit of her food with me.

(P8) Somedays there is no food at all, so my family spends the day without food. I am a housewife; I don't work. I just have to wait until my husband comes home with some beans, green bananas or vegetables from his garden to cook food for the family. On days when there are no crops, my family doesn't eat.

Lack of money. All of the participants expressed their experiences with lacking money to afford food, basic health care needs and services, and transportation. About 80% of the participants reported that they were unemployed with a monthly income of less than $1,000 HTG (US$12). Eight out of 12 participants were single mothers living with between 4 to 6 people in their household. Because it took more than 1 hour to get to the city, all of the participants reported that they could not afford to go to the city to received health care, even when necessary. The following were some of the responses that captured the essence of this code:

(P5) I desire to build a bigger house, but my family cannot afford it. There are 7 of us living in a tiny mud house with just two small bedrooms. I need a house to live in.

(P1) Being poor affect my health because I cannot afford health care, I cannot afford medicine, and I cannot even afford food and drink. I drink water directly from the spring and sometimes it is dirty.

(P2) My health status is influenced by poverty because I can't afford better health or a better lifestyle. I don't have money for medicine, for a checkup with a doctor, and to buy good nutritious food to eat.

(P7) I only have four teeth left in my mouth. I cannot fix them or buy new teeth because I don't have money. I cannot go to the hospital for regular check-ups because I am broke, I have no means to do so.

(P3) When a member of the family is sick, I boil tea leaves until we feel better. I don't have money to afford regular health care or medicine. If it is a health emergency, then I would borrow some money from the neighbor to seek health care in the city. Sometimes I avoid going to the hospital because I have no money and the round trip transportation to the city's hospital is too much.

Low socioeconomic status. Socioeconomic status in this study was measured as a combination of education, income and employment factors. Low socioeconomic status and its correlates such as unemployment, income level, and low educational attainment were among the reoccurring concepts in the participant's responses (12 out of 12). It is widely recognized that people's health is profoundly influenced by a range of social factors outside of health care (Olshansky et al., 2012). The differences in morbidity and mortality rates are patterned after social determinants of health such as education level, employment status, and income level (WHO, 2008). Indeed, educational, employment,

and income factors are essential to one's social and financial development and have a profound impact on the study's population health. The following were some of the responses that captured the essence of this code:

> ***Low income***. (P9) My economic status and living in poverty affects my health. Food comes before health because you need food to survive. Whatever money I have, it not enough for both: health and food.
>
> (P6) I wouldn't mind spending millions of dollars to have health, health is everything, but there is no money at all. It only cost $40 (US$1.86) to go to the clinic, but if I don't have that to pay, even if I am in need, I stayed home.
>
> (P8) I don't have steady employment. I don't have steady monthly income either. Whatever I make, I use to buy food for myself and my kids; there is nothing left to save at the bank. I make about $200 a month (US$12).
>
> (P1) I am not working; I make no money. I don't have a consistent financial resource. Some days they send the kids back from school because I am behind on the monthly school payments.
>
> ***Unemployment***. (P4) I don't have my own house. I am staying with a friend. I don't have any crops that I can sell to make money. I have no education either, so it won't be easy to find a good job in the city if I were to leave this area.
>
> (P1) This area offers nothing, no job opportunities, no gardening work. I spend most of my time sitting around because there is no job. If I had some money, I would buy crops from the farmers and resale to make some benefits. This village is affected by unemployment, and people lack enough to live.

(P5) I am unemployed so I go around to find out who needs a hand throughout the day to help them out for some change and I make about 200 HTG (US$1.86) a month if it's available). For example, if someone needs help handwashing clothes or need help gardening. I help them to make a little bit of money.

(P3) In a way, if you live in this village you will be affected by unemployment and lack enough money to live comfortably. But some of us have it way worst especially those without a man to help out and those with more kids.

Low education level. (P8) Every aspect of my life is affected by poverty as I mentioned earlier. My kids are struggling to eat and going to school. I would love to send all my kids to school but I don't have the means. There are no jobs opportunity in this area. If I found a good paying job, I would be able to provide the necessities for my family and me. But it is not easy around here.

(P10) My parents were poor. They could not send me to school. I don't know how to read or write because I never went to school. I don't want my kids to grow up cretin, so I sell goats sometimes to make a little bit of money to send only the two oldest to school.

(P7) I am a widow with three kids without additional support. I have no garden to grow crops to feed my family or to grow crops for sale at the market. I don't have a home; I am currently staying with close relatives who are helping me out with the kids. I struggle to send the kids to school and keep them in school.

(P11) I did not go to school. If I grew up in the city, then I would have a higher chance of getting an education, but I grew up in this village. I am unable to send two of my kids to school because of lack of money.

Poor living conditions. Poor living conditions were linked with a variety of health conditions, including respiratory infections, tuberculosis, asthma, and other chronic and infectious diseases (Krieger & Higgins, 2002). Based on the interview responses, the findings indicated that respiratory issues, skin conditions, and diarrhea due to untreated water made up 40% of the participant's responses. Situations of poor living conditions, including an absence of safe drinking water, ineffective waste disposal, rats and insects infestations (disease vectors), and improper food storage have long been identified to contribute to the spread of diseases (Krieger & Higgins, 2002). In this study, crowded homes, homelessness, poor sanitation, and lack of necessities produced the poor living conditions theme affecting the health of poor rural Haitian women in critical ways. The following were some of the responses that captured the essence of this code:

Overcrowded homes. (P2) I desire to build a bigger house for my family, but I cannot afford it. Seven people live in a tiny mud house with just two small bedrooms. I need a house with more space to live.

(P9)I don't have a home. My family sleeps like "sardines in a can" because the rooms are tiny.

(P12) I inherited a one bedroom mud house from my father. That is my place to live with my six kids.

(P10) I had a one bedroom mud house not too long ago that I rented for my four kids and me, but the landlord kicked me out because when my baby daddy left me, I could no longer afford the yearly payments.

Homelessness. (P3) I believe my situation is worse than other women because I don't have a hut, I am currently staying at another person's house until my situation turns around.

(P4) I live with a friend and her husband. I help them out in the house.

(P11) I am in the care of a friend. Somedays, a caring neighbor might give me (50 HTG =less than US$1) to buy something to eat. Otherwise, I am nothing at all.

(P5) I don't have a house to live in. A family member gave me a place to sleep. They share their food with me when they have some, if they don't cook that day, I go without food.

Poor sanitation. (P2) I can't afford to buy bottles of water, so my family and I drink untreated water from the spring in the river. We bathe in the river, and we use it to cook too.

(P5) This village has one river, I use the water to bathe in, sometimes the water is dirty, but that is the only water for the whole village.

(P7) I used the canal water to bathe myself and my son. I develop a type of skin allergies because the water is not clear and it is not treated.

(P11) I buy treated water for him to drink but I bathe him with the canal water. I also used that to cook for the house.

Lack basic necessities. (P5) I cannot afford a bed to sleep on; I just put a sheet on the floor to sleep. The floor of the hut is not done, it is always dusty. I cannot afford to buy a pair of sandals. This dress I have been wearing it for four days. I don't have any good clothes to wear.

(P2) I don't have any clothes to go to church services, I don't have shoes that's why you see me walking around barefoot all day, and I depend on my nephew for shelter and food. On days when he can't afford to provide for food, I don't eat anything.

(P6) I can't send all of my kids to school. I can't afford food to give them every day. It is even hard to afford clothes. They have one pair of shoes each, for the church. Look at my 6-year-old; he walks around naked all day because the little clothes he has is for when we are going to church. I am barefoot, and all my kids are barefoot even when the ground is hot or wet.

(P1) I walk around barefoot because I cannot afford to buy a pair of sandals. You see my clothes, they have holes, and they are old because I cannot afford the fabric to make new clothes and pay for the tailor/seamstress to make them for me. My youngest son is nine, he is school age, but he cannot go to school because I don't have money to afford school for all three at the same time. You see him over there without any clothes because the little clothes he has is for when we go into the city.

Theme 2: Barriers to Health Care

The barriers to health care theme included factors such as transportation challenges, lack of health services, and neglecting health care regularity. According to Healthy People 2020 (2014), rural residents should be able to use health care services conveniently (para.1). Based on the participants' responses (12 out of 12), all of these women often experienced barriers to health care that limited their ability to receive the care they needed. Higher poverty rates contributed to the barriers for rural communities in accessing health care services (Lankila et al., 2016). In rural Haiti, the lack of reliable transportation and lack of health services and professionals were among the barriers to health care based on the participants' responses (12 out of 12) that contributed to more health challenges. The following codes indicated barriers to health care among poor Haitian women living in rural regions of Haiti that contribute to further health challenges. Some of the responses that captured the essence of this theme were as follow:

Transportation. Distance barriers, no cars, no transport at night, no hospital and no emergency room were among the factors that made up the transportation code affecting the lives and health of poor rural Haitian women because they were unable to access health care when necessary. Participants from both rural communities (12 out of 12) reported transportation-related issues as a central factor impacting their access to better health care services in the nearby cities. The following were some of the responses that captured the essence of this code:

(P1) When the river flooded, I can't go anywhere even if is an emergency. There are no ambulance services. There are no roads for cars around here, and I am usually too hungry and too weak to walk a long distance to go to the clinic.

(P2) There are no ambulance services, there is no hospital nearby, and there is no pharmacy. The hospital is too far. If I am in labor, I have to call a midwife because the village clinic is 30 minutes away walking distance and they closed at 4 pm. There is a village clinic about 30 minutes away walking distance, I cannot walk for that far now that I am sick, and it would take me two days to get there because my knees are in pain I would need to stop often to catch my balance. I just don't go.

(P5) There is a village clinic about 30 minutes away walking distance; I cannot walk for that far now that I am sick, and it would take me two days to get there because my knees are in pain. I would need to stop often to catch my balance. I just don't go.

(P9) What many of the challenges people encounter around here is the distance and the cost of transportation.

No transport at night, no hospital or emergency room. (P8) Not long ago, this guy got hit in the head with a rock and his head was bleeding, it was only about 6 pm, and the clinic was closed. He had to put a shirt over it to stop the bleeding and walk a long distance to get to the taxi station first, there he had to wait for the next taxi cab to drive him to one city first, from that one city he had to take another taxi to the main city's hospital for immediate care and stitches.

(P12) I normally check out the surrounding villages' clinic first before going to the hospital because it is normally cheaper. These clinics are at least 1 hour away walking distance. It's a lot of walking, and you have to cross a major river on foot before you made it there. It's cheaper, but it's far.

(P3) The hospital is too far. The only village clinic closes early. If there is an emergency in the middle of the night people either suffer and wait for the morning, call on the village vodou priest, or die if they can't wait till morning.

(P9) My life is at risk, my kids' life is also at risk, if we have a health emergency, we could die. The nearest hospital with an emergency room is 4 hours away. If we have an emergency at night time, we have to wait for the morning, there are no cars for transportation at night, and ambulance services are unheard of around here. When someone passes out around here, they use moonshine to revive you and if it doesn't work and you die, four people carry your body on an old wood door, cross the river, and walk a long distance out of the village to get to the main street where cars are passing by to transport the body to a morgue.

Lack services. Access to quality health care services is important for the improvement of health and for increasing the quality of a healthy life for everyone (Healthy People 2020, 2014). The lack of health care services in rural Haiti impaired health outcomes by preventing women from attending to acute and chronic health problems reducing the likelihood of seeking follow-up care. According to the participants' responses (eight out of 12), this lack of service was the reason certain diseases were not being treated promptly. The lack of health care services impacted

people's ability to reach their full potential, and negatively affected their quality of life. According to the data, lack of services related factors such as no ambulance or pharmacy services, village clinic closes early, village clinic is understaffed, and village clinic is ill-equipped made up the lack of services code that affected the lives and health of poor rural Haitian women in important ways. The following were some of the responses that captured the essence of this code:

> (P7) There are no ambulance services, the village clinic closes at 4 pm, and there are no doctors around here, just one nurse. They ask for $100 or $200 ($US1.50), but I don't have that. So I choose not to go at all if I can't afford it. Sometimes I have my period, and the cramp gets unbearable all day all night for three days straight, I can't afford a $1 (.10cents) pain relief medicine to help me feel better, you see. I can't even buy tampons; I used fabric to hold the blood and wear three underwear until it stopped. I don't have any money, and my parents don't have any money available for me to ask them for money.
>
> (P2) There are no ambulance services, there is no hospital nearby, and there is no pharmacy.
>
> ***Village clinic closes early, is understaffed, or ill-equipped***. (P2) If I am in labor, I have to call a midwife because the village clinic is 30 minutes away walking distance and they closed at 4 pm.
>
> (P7) One day my little brother got infected with cholera, it was around midnight, the village clinic was already closed at that time, and transportations was not

available. He suffered from a high fever and diarrhea all night long because this village had no resources for emergencies such as these.

(P5) When it comes time to give birth, I stay at home. Then after the baby comes, I send for a midwife to cut the umbilical cord. There is no doctor in this village to help with baby delivery, only midwife. Even if there was a doctor, the village clinic closes early. There are no ambulance services to take you to the city hospital when you in labor.

(P8) There is only one clinic in this village with only one nurse to give you a checkup, and pain pills before she referred you to the city to see a doctor. There is no doctor in this village.

Neglecting health care. Neglecting health care affected the participants' health in both direct and indirect ways. The immediate negative impact among the study participants' included dental problems, lack of preventative care such as vaccination, and chronic illnesses which can be translated into lifelong health consequences. The conditions that were mentioned the most included missing teeth (five out of 12 women), chronic illnesses (nine out of 12 women) and no vaccination (11 out of 12 women and their children). Factors such as neglecting health, ignoring health issues, and avoiding check-ups made up the neglect health care code that increased the risk of morbidity and mortality among rural Haitian women and their children. The following were some of the responses that captured the essence of this code:

(P1) I only have 4 teeth left in my mouth. I cannot fix them or buy new teeth because I don't have money. I cannot go to the hospital for a regular check-up because I am poor, I have no means to do so.

(P6) Because I am poor, I don't have money to see a doctor or to take my kids to see a doctor even when it is necessary.

(P8) I would love to have been able to go to the hospital for a checkup, but if I don't have money, I cannot go. My kids have never been to the doctor for vaccination, even though I know it's necessary but with what money.

(P4) My health status is not a priority for me even when I know I am in need of a doctor and medication to help me with my dizziness.

Theme 3: Alternatives to Health Care

According to the interview responses, all 12 participants used traditional medicine and self-treat as a way to support their health or to avoid illnesses. Home remedies usage were very common among the study population. When it becomes clear that an illness required attention, the participants sought medical care. The alternatives to health care theme included two factors: alternative medicine and spirituality. Based on all the participants' responses (12 out of 12), these codes indicated that in the absence of resources to obtain medical care, poor Haitian women living in rural regions of Haiti relied on alternative health care practices. The following were some of the responses that captured the essence of this theme:

Alternative medicine. Traditional healing practices and vodou priest consultation made up the alternative medicine code that described the various alternative medicine

methods that poor rural Haitian women relied upon when they were sick. Based on the interview responses, nine out of 12 participants talked about vodou practices and vodou priest consultation as an alternative to medical care. The following were some of the responses that captured the essence of this code:

> (P12) I stick with traditional medicines using tree leaves and greens. For example, for my son's belly inflammation, I try every traditional medicine under the sun already. Whatever someone in the community recommends, I do it for him.
>
> (P7) I boil leaves in a big pot and bathe with the leaves water to relax my muscles. I make tea too to drink to help me feel better. If it's a fever, I apply watermelon peel on the forehead so the cooling effect can bring the temperature down.
>
> (P2) It is cheaper to see a vodou practitioner for healing. Because of this, sometimes I go out to see a vodou priest to find out what's going on with my body.
>
> (P1) If we had money at the time of the sickness, we would go to the hospital, but if we don't have any money, we don't go to the hospital. I boiled tea leaves for relief instead. If it is something bad, then I see a vodou priest to tell me what's going on.

Spirituality. Factors such as faith in God for healing, praying to God and hoping in God to change situations made up the spirituality code that showed how poor rural Haitian women relied on spirituality to help them through hard times. Many participants (eight out of 12 women) mentioned their reliance on God and prayers for their health issues. The following were some of the responses that captured the essence of this code:

(P1) I cannot go to the hospital for a regular check-up because I am poor, I have no means to do so. I just get on my knees and call on God to help me.

(P5) My health is in need for improvements but how can I do anything with no money. No one would want to live in pain constantly, but I don't have a choice, I can't steal money, I am not able to work, I just stay and suffer, maybe one day God would heal me.

(P10) I have not received post-birth care since I gave birth 2 months ago. I thank God because my kids don't get sick, He sees that I can't handle double the trouble.

(P11) I don't have any money to go to the doctor. I just sit around and hope that God will hear my prayer. I know health is everything but only when you have the money. If God is willing to do something for me, then I'll wait. I am God's daughter, not his step daughter, you know.

Theme 4: Effects of No Care

The effects of no care theme included factors such as chronic stress, chronic illnesses, teenage pregnancy, infant mortality. Based on all the participants' responses (12 out of 12), these illustrated the health outcomes that resulted from lack of health care among poor women living in rural regions of Haiti. The following were some of the responses that captured the essence of this theme:

Chronic stress. Poverty is stressful. The continuous absence of money, unhealthy living circumstances, the awareness of inferiority to those of higher socioeconomic status, and the overall feeling of not being in control of one's life all contributed to the

higher chronic stress levels in poor Haitian women living in rural Haiti. Living with chronic stress, anxiety, and worries made up the chronic stress code that affected the lives and health of poor rural Haitian women in important ways. Eight out of 12 participants talked about their experiences with daily stress, anxiety, and humiliation. The following were some of the responses that captured the essence of this code:

> (P3) I am very stressful. I stay at home, laying on my belly thinking about what to do because there is no way.
>
> (P10) I worried how I would take care of my baby every day, but my neighbors give me food to give him on days when I have no food for him. When I was pregnant with him, I worried so much about how I would provide for a fourth child that I wanted to abort the baby.
>
> (P12) I think about my problem, and it weighs heavily on me to a point I would leave my house to go somewhere, but I forgot where I meant to be going.
>
> (P6) Of course, my experiences in life for being poor affect my health. Listen, I used to be a big woman, but I think too much and now look how thin I am. I look older than I am too because my situations and life problems weighed heavily on me.

Chronic illnesses. Chronic illnesses such as dizziness, joint pain, hypertension, vaginal discharge, migraine, skin rash, mental stress were mentioned most. Eight out of 12 participants suffered from a different type of chronic illness. Three out of these eight women talked about their kids experiencing chronic illness as well, and they were not able to take them to the doctor. These women knew the daily struggles of performing the

simplest things in life such as walking. They expressed their struggles with frustration, anger, and confusion when they talked about living a life filled with physical and emotional pain. The fear of not knowing how much control their pain will have over their day to day tasks was expressed with their stories and experiences. Participant responses to the code for living with chronic illnesses for 3 years or more illustrated the long-term effects of living in poverty. The following were some of the responses that captured the essence of this code:

> (P12) You see, I have chronic hypertension. I have to stop to catch my breath every time I walk. I have to follow a strict diet regimen. I would love to take medicine to help and see a doctor for a regular checkup but it's not possible because I am poor, I am struggling to get by with six kids, I have no money.
>
> (P9) The vaginal discharge is chronic; it never stopped since my first pregnancy 3 years ago. I went to see the nurse at the clinic once but I cannot afford the antibiotics for the infection, so I stop going. Even if I am in need of a doctor, I am not able to go because I have no money. People say that this illness could affect the baby in my belly, but I have no money to take care of it.
>
> (P5) All I do is lay down; I don't do anything else because I suffer from a chronic migraine. Also, about 3 years ago I develop a skin rash. Look how scaly my skin is, my skin is scaly and dry. I cannot afford to see a doctor; I just leave it like that. If I have a little bit of money, I use it to buy food. Sleeping on the ground and bathing with the river water only make my skin conditions worst.

(P4) My knee joints are always in pain. All I can do is lay down waiting for my last day on this earth.

Teen pregnancy, infant mortality, stillborn babies. Lack of opportunity and hope for the future, was identified as the driving force behind teen pregnancy experiences among the participants. According to 50% of the participants, poverty factors such as malnutrition, poor living conditions, and lack of prenatal care accounted for teenage pregnancy, stillborn babies, and infant mortality prevalence. Teenage pregnancy (two out of 12), stillborn babies (two out of 12), and infant mortality (two out of 12) factors were other health outcomes experienced by poor rural Haitian women who lacked access to health care. The following were some of the responses that captured the essence of this code:

(P9) I became pregnant that same year at only 14 years old. After the baby was born, they didn't want to help me, they took my bed away, and I ended up sleeping on the floor with the baby. They gave me no food to eat; I couldn't produce milk to breastfeed my baby. My child dies after a year.

(P5) I had five kids but all five of them passed away when they were infants.

(P2) Because of living in poverty I miscarried one of my children. I am currently 5 months pregnant, and I have never seen a doctor for a checkup.

(P8) I was living on the street until I met the first man whom I had two kids with but they both died before the age of three, so the first man left me. I met the second man and had three kids with him, but he died shortly after my third

pregnancy, I was left all alone to take care of all three kids. One of them was born dead, the other two died before they were 20.

No prenatal, postnatal, or women's care. Pregnancy and birth are among the life events that shape health outcomes within the course of an individual's lifetime. All of the participants (100%) reported their experiences with the lack of maternal health and emergency obstetric care at some point in their lives. In rural Haiti, the impact of poverty on pregnancy and childbirth influenced many adverse concerns experienced by those living in poverty. Lack of prenatal, postnatal, and women's care were examples of how poor rural Haitian women lacked access to health care. The following were some of the responses that captured the essence of this code:

(P10) I never received prenatal care or post-birth care for my first three kids because I don't have money.

(P12) Some of my kids were vaccinated, but I didn't do prenatal care or post-birth care for any of my children.

(P2) Because of living in poverty I miscarried one of my children. I am currently 5 months pregnant, and I have never seen a doctor for a checkup.

(P8) Throughout all four of my pregnancies, I couldn't see a doctor for a checkup because I have no money. I would love to have been able to go to the hospital for a checkup but if I don't have money, I cannot go. My kids have never been to the doctor for vaccination, even though I know it's necessary but with what money.

Themes and the Theoretical Framework

Chapter 1 indicated that the theoretical base for this study involved Bronfenbrenner's (1979) SEM for population health development and behavior (Bronfenbrenner, 1979). The authors described the SEM as a mechanism to understanding individual behaviors by considering the different levels of social factors that can influence behavior. As such, the SEM provided a framework to highlight similarities and differences in the perception of poverty in rural Central Haiti. The theory emphasized that individual health development and behavior are influenced by the different types of environmental systems. The theory is made up of four systems that influenced an individual's behavior: microsystem, mesosystem, exosystem, and macrosystem (Bronfenbrenner, 1979). These different system levels found in the data explained the relationship between the poverty phenomenon and women's health. The following were some of the responses that captured the essence of the SEM theoretical framework:

Microsystem. The microsystem experiences included social interactions between people and their immediate environment. The following responses illustrate how friends and family influenced the health of participants such as close relatives helping out, friends and neighbors sharing food and lending each other money:

> (P11) I am currently staying with a close relative who is helping me out with the kids.
>
> (P3) I don't have money to afford regular health care. If it is an emergency, then I would borrow some money from the neighbor to seek health care.

(P4) When my friend is here, and she cooked, I have a little bit to eat. If my friend is not here, I don't eat because I don't have money to buy food or a garden grow my food.

(P9) When someone pass out around here, the neighbors use moonshine to revive you if it doesn't work and you die, 4 people carry your body on an old wood door to cross the river, and walk long distance out of the village to get to the main street where cars are passing by to transport the body to a morgue.

Mesosystem. The mesosystem experiences included interaction among multiple individual microsystems in which a person functioned. School experiences, no education, and being multigenerational illiterate were predominant issues that impacted the lives of poor women living in rural Haiti. The following participants' statements illustrated aspects of the mesosystem:

(P10) My parents were poor. They could not send me to school. I don't know how to read or write because I never went to school. I don't want my kids to grow up cretin, so I sell goats to make a little bit of money to send the two oldest to school.

(P1) My youngest son is nine, he is school age, but he cannot go to school because I don't have money to afford school for all three at the same time.

(P2) My situation handicaps me in all aspect of my life. I would love to send my kids to school for an education but I can't.

(P3) Somedays when I send the kids to school, the principal send them back home because I am behind on the school payments.

Exosystem. The exosystem were the experiences prompted by the external environment that indirectly affected one's development. The codes that fall under exosystem included transportation and unemployment issues: No roads for ambulance, hospital long distance, and lack of employment opportunities. The following participants' statements illustrated aspects of the exosystem experiences:

> (P1) This area offers nothing, no job opportunities, no gardening. I spend most of my time sitting around because there is no job.
>
> (P4) I am unemployed so I go around to find out who needs a hand throughout the day to help them out for some change and I make about 200 HTG ($US 1.86 a month) if it's available.
>
> (P9) The cost of health care is not affordable in this country; the village clinic doesn't have a doctor, the nurse always gives you pills and refer you to a doctor in the city, it is too far, transportation costs money. I stop going.
>
> (P10) If I am sick and I don't feel well to go to the city alone, if I don't find someone to take me, I don't go; If I don't have enough money for both transportation and the payment to see a doctor, I don't go

Macrosystem. The macrosystem represented the values, traditions, culture, history, and laws that were considered significant in the person's life. Rural poor Haitian women identified a variety of factors related to the macrosystem, including culture, traditions, and belief systems such as traditional medicines and healing practices, using a midwife, consulting with a vodou priest, spirituality, and faith in God.

(P1) When my sickness gets out of control, I boil tea leaves to see if I would feel better.

(P7) The first thing I do is pray to God for healing. I also boil leaves in a big pot and bathe with the leaves water to relax my muscles. I make tea too to drink to help me feel better. If it's a fever, I apply watermelon peel on the forehead so the cooling effect can bring the temperature down.

(P2) If we have money at the time of the sickness, we will go to the hospital, but if we don't have any money, we don't go to the hospital. I boiled tea leaves for relief. If it is something bad, then I see a vodou priest to tell me what's going on.

(P8) I gave birth to all four of them at home because I didn't have money to go to the main hospital in the city.

Summary

The results of this study revealed the clear and significant data describing the feelings, thoughts, and experiences of rural Haitian women who lived in poverty. Most participants in the study seemed to share similar thoughts and lived experiences on the poverty phenomenon and the way it impacted their health. Many of them had the same concerns about how poverty influenced their access to health care services and their overall health status. A clear connection existed between each of the themes and the theory used. Chapter 5 will include an in-depth examination of the association between the SEM theory and the themes. In Chapter 5, I will also discuss my interpretation of these findings, social change implications along with recommendations for action and further study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this phenomenological qualitative study was to develop a greater understanding of the factors that impact access to health care services affecting the health of poor women living in rural Haiti. The phenomenon of interest in this study was poverty. Data collected through semistructured interviews with poor women in rural Haiti addressed the experiences related to poverty that, in turn, have an impact on health.

Interview questions related to poverty and its impacts on access to health services generated two themes: (a) barriers to health care; and (b) alternative to health care. Interview questions related to socioeconomic status and its impacts on health generated the other two themes: (c) living conditions; and (d) effects of no health care. In summary, my research findings indicated that barriers to health care, alternative health care, poor living conditions, and the effects of no health care contributed to the way that the poverty phenomenon affected the health and lives of poor rural Haitian women. In this chapter, I discussed and interpreted the research findings of this study related to the SEM theoretical framework and poverty, and health literature that grounded this study. Also, this chapter presented the limitations, recommendations, and implications of this study. This chapter concluded with a summary of the fundamental significance of the study and the need for social change among Haitian women living in poverty in the rural area of Haiti.

Interpretation of the Findings

Poverty is a well-studied and well-documented phenomenon. However, very few studies have focused on the lived experiences of poor women in rural Haiti who have poorer health outcomes as a result of poverty. The literature from Chapter 2 confirmed an apparent connection between poverty and health, particularly in rural Haiti, as poorer people are at a higher predisposition to acquiring illnesses and lack access to medical care once an actual illness is acquired (Larson et al., 2015; Rosseel et al., 2010). While the relationship between poverty and poor health is supported by various studies, a significant gap in the research literature was found. In addressing this gap, my study explored the connection between poverty and lack of access to health services that led to poorer health among rural Haitian women, emphasizing on socioeconomic factors attributable to poverty such as educational level and employment status, lack of access to care, distance challenges, and alternatives to health care.

Poverty, often speculated as an urban issue, is prevalent in rural areas due to underemployment, high rates of poverty, and geographic isolation and challenges. Researchers demonstrated that lack of access to health services was a barrier to accessing basic health care for rural Haitian people (Celik & Hotchkiss, 2000; Falkingham, 2003; Fawzi et al., 2010; Gage & Calixte, 2006; Magadi et al., 2003). In my study, all of the women experienced various challenges to accessing health care services due to transportation issues and unavailability of services, which resulted in neglecting health and health care services. Participants reported many barriers to accessing health services, including a lack of money (100%), no transportation at night in case of an emergency

(93%), long distance to health facility (93%), and village clinic closes early, is understaffed, or ill-equipped (93%). Most of the participants had never had a service provider meet them where they live to offer health services (97%). The findings from my study also confirmed previous studies that indicated lack of medical services or access to health care services increased the likelihood that people living in poverty have minimal access to medical care, transportation, medical supplies and doctors, and are at greater risks of neglecting their health (Hinman et al., 2011). The literature highlighted that the lack of medical equipment and supplies in Haiti hospitals resulted in medical response shortages, and its populations were at greater risks of acquiring diseases (Horvath, 2005; Sweeney, 2010). The result of these studies were confirmed in my study findings.

Poor living conditions finding from my study were supported by the literature, which suggested that socioeconomic status reflected the prevalent and extreme poverty in rural Haiti with 44% of women living in substandard housing conditions (mud shelters, thatched houses), and only 32% of households had a latrine (Fawzi et al., 2010; Urrutia et al., 2012). In regards to shelter and housing situations, 97% of participants reported that they had never owned a home and that they were currently living with close friends or relatives. The top four barriers under poor living conditions were the lack of money (100%), lack of food (100%), lack of employment (90%), and low socioeconomic status (100%). Also, all of the participants (100%) had never experienced governmental intervention for their housing problems or had a service provider or anyone meet with them to help with housing assistance. The literature highlighted that low socioeconomic status were increasingly related to poor health outcomes, diseases, and deaths (Currie,

2009; Pampel et al., 2010). In addition, rural areas are more susceptible to poorer health outcomes because the more remote the area, the fewer the financial mean and the more poverty rates increased (Mosley & Miller, 2004). People with lower socioeconomic status repeatedly have worse health status than individuals with higher socioeconomic status (Currie, 2009; Pampel et al., 2010). The finding from the aforementioned studies were confirmed in my study.

Reliance on alternatives health care including traditional medicine and spirituality were another factor consistently found in my study that had a major influence on health. According to the literature, alternatives to health care medicine included cultural, spiritual, and traditional values that significantly influenced a person's perception of health practices and health care orientation (e.g., home remedies, vodou practitioners and healers known as bokor for male and mambo for female, doktèfey [herbalist], doktèzo [bonesetters], pikirist [injectionist], and fanm saj known as traditional birth attendants or midwives; Desrosiers & St Fleurose, 2002; Khoury et al., 2012; Rahill & Rice, 2010). These findings were confirmed in my study indicating that all 12 participants (100%) used some type of traditional medicine and self-treated as a way to support their health or to avoid illnesses. Participants reported some alternative medicine approaches including boil tea leaves (90%), prayers and faith in God (93%), consultation with a vodou priest (63%), and other traditional healing practices such as using midwife services and bonesetters (83%). Based on the participants' responses, these findings indicated that in the absence of resources to obtain medical care, poor Haitian women living in rural regions of Haiti relied on alternative health care practices.

The effects of no care was another factor found in the literature that was associated with poverty and poor health. Perry et al. (2007) presented substantial evidence of a strong relationship between health systems in an impoverished setting compared with national rates. The findings in this study related to effects of no care included factors such as chronic stress, chronic illnesses, teenage pregnancy, and infant mortality. The continuous absence of money, unhealthy living circumstances, the awareness of inferiority to those of higher socioeconomic status, and the overall feeling of not being in control of one's life all contributed to poor health in the study population. Living with chronic stress, anxiety, and worries made up the chronic stress that affected the lives and health of poor rural Haitian women in substantial ways. Participants reported many factors contributing to poor health that included chronic stress (80%), chronic illness (83%), teen pregnancy (40%), and infant mortality (33%). The responses illustrated the health outcomes that resulted from lack of health care among poor women living in rural regions of Haiti. According to 50% of the participants, poverty factors such as malnutrition, poor living conditions, and lack of prenatal care accounted for teenage pregnancy, stillborn babies, and infant mortality.

Findings Related to the SEM Theoretical Framework

As poverty occurs within the complexities of a wide-ranging environment including individual circumstances, socioeconomic structures, and environmental circumstances, the SEM provided a framework to consider rural poverty and its impact on individual health. The SEM contended that behavior is affected by multiple levels of influence, including intrapersonal, interpersonal, organizational, community, and public

policy, which are shaped by the social environment (Bronfenbrenner, 1979, 1999; Glanz et al., 2008). The SEM framework centered on four systems involved in an individual's environment and the influence these systems have on the individual's health and behavior (Bronfenbrenner, 1979, 1999; Glanz et al., 2008). For this study, the SEM framework was used to understand the systems in the women's social environment that had an influence on their health, health-related behavior, and overall life.

I captured the different systems (microsystem, mesosystem, exosystem, and macrosystem) by utilizing a semistructured interview as a method of data collection. According to Gage and Calixte (2006), distance and poor road conditions negatively impacted a women's decision to seek health and to use health services. My study found that many of the women expressed challenges related to the external environment that influenced their decision to seek health care such as lack of money, transportation challenges, and lack of employment. Based on the findings from this study, I concluded that the women's external environment (exosystem) did play a role in their health, health behavior, and overall life. Based on the results of this study, I also found that the women's social interactions (microsystem) with their immediate environment played a major role in their health and their decision to seek health care services. Interactions among multiple individual microsystems (mesosystem) such as friends and family interactions influence on the participants when close relatives were helping out, friends and neighbors sharing their food and lending each other money. The participants acknowledged a variety of macrosystem factors that influenced their life including culture, traditions, and belief systems such as traditional medicines and healing practices,

using a midwife, consulting with a vodou priest, spirituality, and faith in God. The SEM did help me understand why and how the environment influenced the health behavior of rural Haitian women. Accordingly, all four systems were in alignment with the SEM theory and were found to be influential in the participants' health and health behavior. Because poverty in rural Haiti tends to be lacking adequate poverty-targeted resources, this study suggested that rural regions in Haiti needed to improve how they currently manage poverty using the different levels of influence represented in the SEM.

Limitations of the Study

Limitations of the study include the following: (a) the study was administered to a small sample; therefore, the results may not be generalizable beyond that specific population. Although this study had a small sample size and focused on two rural areas of Central Haiti, the results did support existing research on rural poverty in general. The results, however, cannot be generalized to other unexamined rural regions as they still may vary in how poverty impacts their health as well as due to the small sample size of the study: (b) the study was limited to interviewing participants experiencing the same phenomenon, (c) the study focused on poor women in rural Haiti reporting on their experiences, so knowledge produced may not be generalizable to other people, gender, other settings, and other nations, (d) the study utilized snowball sampling technique as a second strategy to select interview participants and follow-up with participants, (e) many participants were not able to read and write in their native language, and (f) the nature of the chosen research method for this study (qualitative phenomenology) imposed limitations on the replicability of the study.

Other major limitations in studying this population included a lack of awareness and acknowledgment of poverty in rural regions of Haiti. Minimal attention has been given to how rural poverty has impacted the health of Haitian women living in rural areas. To my knowledge, this study is one of only few that have been conducted to examine how poverty affects women's health in rural regions of Haiti. The lack of data for poverty and other socioeconomic variables illustrated not only the political instability in Haiti but also the lack of attention given to these aspects of development in Haiti's past. There is no doubt that bias occurred, but I have made any assumptions clear and open to be examined for bias. For example, self-reporting bias may occurred as the participants may have exaggerated or left out information due to poor memory; measurement bias was another possibility as the poverty topic is not a well-defined concept. As a result, participants may have had a different definition from the researcher, and other readers may defined the concept differently. Overall, I strived to keep a strong professionalism to be more objective and expressed in the field notes any personal involvement that influenced or biased the study results.

Recommendations

Because it is unclear whether my study results would generalize to different parts of Haiti with different levels of poverty; future studies could investigate poverty experiences in other rural regions, either within Haiti or nationwide, and compare them to the perceptions and experiences expressed in this study. This study only provided a surface-level description of rural poverty rather than a deeper exploration of the interaction of the SEM levels related to poverty. Future studies could explore the

additional levels in greater depth by investigating the perspectives of families, friends, and community networks. Future research could also consider how policies, communities, organizations, and individuals develop and implement initiatives to alleviate circumstances related to poverty. This research did not involve any stakeholders or community partners; therefore, future researches looking at rural poverty should make an effort to include community partners as they can play an important role in addressing their community issues. The significance of this study had to do with the social, community, and individual impacts that poverty has on health. As a result, facilitating equitable access to resources and opportunities makes it more possible to accomplish a wide variety of development goals. To future researchers, this study can provide baseline information on the issues of poverty in rural Haiti.

Positive Social Change Implications

Consistent with Walden University's definition of positive social change, any research related to efforts and ideas to create positive social change and focused on real-world applications of these efforts and ideas had positive social change implications. For this research, exploring essential policy-oriented factors such as poverty and socioeconomic status and their influences on rural Haitian women's health status, and access to health care services could advocate for positive social change strategies and efforts both at the individual and institutional level to make significant contributions to improving public health conditions particularly for Haitian women living in poverty and for advancing the Haitian society as a whole. Therefore, I conducted this study to focus

on efforts and real-world applications to increase access to health care services to generate positive social change implications.

McLoughlin and Young (2005) stated that public health research has gradually improved the context and content of poverty-related policy considerations. The findings of this study could help develop new programs for women in rural areas to improve their health status. Moreover, this study will create positive social change by encouraging more research in the areas of poverty and its impact on health among rural Haitian women, by focusing more closely on social factors influencing poverty such as education level, income level, and employment availability. In addition, social change will engender the promotion of a better understanding of the dynamics of poverty in poor health. Lastly, this study will contribute toward developing better social conditions to prevent and reduce poverty in rural regions which will improve overall health, particularly women's health.

In an attempt to have an adequate supply of health care services and health care access, appropriate and necessary services must be accessible to rural residents. For example, in order to have sufficient health care access, a rural resident requires: (a) money to pay for the different health services; (b) transportation services as a means to reach and use services located at a distance; (c) and assurance in the quality care that they will be receiving. Based on the finding of this study, rural health care inconsistencies require a continuous program of reform aiming at promoting training of rural health care professionals, engaging health care providers and rural residents in health promotion, and improving the provision of health care services that include more clinics nearer to the

villages and staff on call 24 hours a day, 7 days a week. Additionally, job development policies can create more job opportunities in rural areas. Free education policies and schools that are closer to the villages can help reduce the financial issues of poor women unable to afford an education for their children. The villages are in great need of a public water pump to promote the usage of treated water and to help water the farmlands so poor women can grow more crops to sell and to feed themselves and their family.

Conclusion

The study findings demonstrated to what extent poverty affects the health of Haitian women living in rural areas of Haiti. Consistent with the literature, poor health in rural Haiti tends to be caused by poverty contributable to lack of food and money, lack of access to health care services and resources, low socioeconomic status, and alternative medicine. From the SEM perspective, the study suggested that the interactions between communities, government, and individuals influenced accessibility and availability of health services for people experiencing poverty in rural regions of Central Haiti. Overall, this study suggested that rural regions need to improve how they currently handle poverty using the different levels of influence represented in the SEM. Rural regions in Haiti can be improve by recognizing that rural poverty differ from urban poverty; hence, improving communication, coordination, and collaboration of both medical and nonmedical services available to individuals experiencing poverty in rural areas can significantly impact lives. My study results provided empirical evidence on poverty among women living in rural Haiti. These findings can help policy makers who are considering poverty associated regulation used to combat poverty, particularly in rural areas of Haiti. This study is a

stepping stone for future research to begin to understand the extensity of rural poverty in Haiti and its influence on health and to further consider how to translate the distinct findings at an intrapersonal, interpersonal, and organizational level to inform poverty-related policies and interventions. Much of public health advocacy is grounded on seeking policies to address inequities in variation in health outcomes and access to health care services among all groups of people seeking social justice. Although important and commendable, I think such goals need to be reinforced by educating policymakers about the real economic benefits of investing in public health interventions. The findings of this study indicated that improving social, living, and job conditions would have a significant impact on the health of poor women in rural Haiti as well as their families.

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Appendix A: Interview Guide (English & Haitian Creole)

Poverty experiences in rural Haiti

1. Tell me about a typical day in your life?

   Probe: Is your life similar to other women living in this part of Haiti?

2. Would you describe yourself as poor? If yes, why?
3. Can you describe any particularly difficult experiences in your life related to being poor?
4. Did any of these experiences affect your health? If yes, how?

Occasional Check-ins: How are you doing? Do you need a break?

Rural poverty influences on access to health care services and health status

5. What do you do when you, or one of your family members gets sick?
6. Where do you get health care?

   Probe: How do you get there? Is it close to your home? What type of care is it (hospital, public, private, other)?

7. Do you ever avoid getting health care because you can't afford it?

   Probe: Can you describe a situation when you decided not get health care? Did the cost of health care impact your decision?

8. Have you experienced any challenges with access to health care?

   Probe: Please share any specific challenges you had with paying for basic health needs? How did this influence your lifestyle choices?

   Occasional Check-ins: How are you doing? Do you need a break?

Rural poverty factors influence on overall quality of life

9. Does being poor affect your health?

   Probe: In what ways does poverty influence your health status?

10. How does being poor affect your overall quality of life?

    Probe: How does poverty impacts your education level? How does poverty impact employment opportunities in your neighborhood? Have you had a job in the past? Tell me about your experiences.

Interview Guide in Creole

Experyans povrete nan region andeyo an Haiti

1. Explike mwen oubyen pale mwen de koman yon jou normal ye pou ou? Koman w pase yon jounen ? Kisa ou fai nan yon jounen ?

   Sonde: Pale mwen koman ke lavi ou diferan ak lavi tout lot fanm kap viv nan zon sa?

2. Ou panse ou nan kategori moun ki pa gen ase mwayen pou yo viv byen? Si repons la se wi, di poukisa ou panse sa?
3. Ou ka pale de difikilte ou rankontre paske sitiyasyon yo difisil pou ou?
4. Nan ki fason sitiyasyon wap viv ladan-l la afekte sante ou? Eske ou konn besyen al lopital men ou pa gen lajan pou w ale ? Si repons la se wi, explikem nan ki fason?

   Verifikasyon Okasyonel: Koman ou ye ? Ou ta vle fai yon ti poze?

Povrete nan zon andeyo ki afekte mwayen pou yon moun jwenn sante

5. Kijan ou fai, ou du mwens, pa ki mwayen ou pase le ou menm oubyen yon menb nan fanmiy la tonbe malad?

6. Kibo ou ale le ou bezwen jwenn swen sante?

   Sonde: Pa ki mwayen ou pase pou ale? Eske se yon kote ki lwen? Eske se yon clinic, lopital, sant de sante public ou prive, oubyen yon lot mwayen diferan?

7. Eske ou konn oblije neglige sante ou oubyen ou pa al lakay dokte akoz ou pa gen lajan?

   Sonde: Pale mwen de yon situasyon kote ou decide pou pa al pran swen de sante? Explike mwen yon sitiyasyon kote ou pat ale lopital akoz ou pat gen lajan ? Eske kantite kob yo mande pou peye konn fe ou pa ka al pran swen pou sante ou?

8. Ki kalite de lot difikilte ke ou konn rankontre le ou ta vle al pran swen sante?

   Sonde: Koman esperyans sa yo afekte eta sante ak jan ou ta anvie viv?

   Verifikasyon Okasyonel: Koman ou ye ? Ou ta vle fai yon ti poze?

Povrete nan zon andeyo ki afekte lot aspe nan vi a

9. Ou panse ke situasyon ekonomik ou afekte sante ou ?

   Sonde: Nan ki fason sitiyasyon ekonomik ou afekte sante ou?

10. Ki lot aspe nan lavi-w ke situation povrete sa afekte?

    Sonde: Nan ki fason povrete afekte nivo edikasyon ou? Eske povrete ki nan zon nan afekte oportinite pou jwenn travay? Ou kon jwenn jwenn ti travay deja? Pale mwen de esperyans sa.

Appendix B: Demographic Survey (English & Haitian Creole)

GEOGRAPHICAL AREAS /REGION: What area of the country do you reside in?

(A) Rural

(B) City

AGE: What is your age category?

(A) 18 to 24 years

(B) 25 to 44 years

(C) 35 to 54 years

(D) 45 to 64 years

(E) Age 65 or older

SELF-IDENTITY: What do you identified yourself as?

(A) Heads of households

(B) Housewives confined to traditional roles and activities

(C) Domestic servants

(D) Charcoal producers/vendors

(E) Rural agricultural workers, farmers, and sharecroppers.

EDUCATION LEVEL: What is your education level?

(A) No education

(B) Completed some primary

(C) Completed some secondary school

(D) Completed some college/university

(E) Other degree beyond college level

MARITAL STATUS: What is your marital status?

(A) Single (never married)

(B) Married

(C) Separated

(D) Widowed

(E) Divorced

HOUSEHOLD: How many people are there on your household?

(A) 1

(B) 2

(C) 3

(D) 4

(E) 5

(F) 6 or more

TYPE OF EMPLOYMENT: How many hours per week do you USUALLY work at your job?

(A) 40 hours a week or more

(B) Less than 40 hours a week

(C) I am not currently employed

What best describes the type of job you do?

(A) Agricultural

(B) Government

(C) Health Care

(D) Education

(D) Charcoal Producer/Vendor

(E) Domestic Servant

(F) Other or Informal sector or free lance

INCOME: What category does your monthly income fall under?

(A) 1000 Gourdes ($US 12)

(B) 3000 Gourdes ($US 27)

(C) 5000 Gourdes ($US48)

(D) 6000 Gourdes or more ($US60 or more)

ACCESS TO CARE: How many health centers, clinic, or hospital are in this region?

(A) 0

(B) 1

(C) 2

(D) 3 or more

How far are the community health centers, clinic, or hospital from your home?

(A) Less than 1hour away

(B) More than 1hour away

What type of transportation do you most often use to get from point A to point B?

(A) Walking

(B) Horse or donkey ride

(C) Bicycle

(D) Motorcycle

(E) Public transportation (Tap-Tap, Car Taxi, Bus)

Additional Notes/ Participant Recommendations

Appendix B: Demographic Survey in Creole

L'enquête démographique

Zones Géographiques /RÉGION : Nan ki zone ou habite?

(A)Andeyo

(B) laville

L'AGE : Nan ki catégorie l'âge ou tonbe?

(A) de 18 à 24 ans

(B) 25 à 44 ans

(C) 35 à 54 ans

(D) 45 à 64 ans

(E) l'âge de 65 ans ou plus l

IDENTITÉ - W: Koman ou identifye tet ou?

(A) Chefs kay la

(B) Madan marye (C)

(C) ou fait oubyen ou vann charbon

(D) ou travay nan pati agricol.

Niveau Lekole ou : Ki klas ou fait?

(A) Klas primaire

(B) complété études secondaires

(C) Ou pa janm ale lekol

ÉTAT CIVIL : Ki stati état civil ou?

(A) célibataires (pa janm marye)

(B)séparés

(C)Divorcée oubyen Veuve

Kay la : Combien moun ki sou responsablite ou ?

(A) 1

(B) 2

(C) 3

(D) 4

(E) 5

(F) 6 ou plusieurs

TYPE D'EMPLOI : Combien heure de temp ou travay?

(A) 40 heures par semaine ou plus

(B) moins de 40 heures par semaine

(C) Mwen pa nan travay

Ki type de travail que ou fait ?

(A) l'Agriculture

(B) santé

(C) l'éducation

(D) producteur/vendeur chabon

(E) Domestique

Revenu : Ki catégorie revenu ou pa mwa ?

(A) 1 000 gourdes ou mwens ($US 12)

(B) 3000 Gourdes ($US 27)

(C) 5000 Gourdes (US48)

(D) 6000 Gourdes ou plus ($US60 ou plus)

ACCÈS AUX SOINS DE SANTE: Konbyen centres de santé, clinique, ou l'hôpital ki nan région sa?

(A) 0

(B) 1

(C) 2

(D) 3 ou plus à

Ki distance ki genyen entre centres de santé yo/ clinique ou hôpital ak lakay ou ?

(A) moins ke une heure de temp

(B) plus ke une heure de temp

Ki type transport ou utilisez plus souvent ?

(A) l'âne ou bourik

(B) moto

(C) Transport public (Tap-Tap, taxi, bus)

Notes additionnelles/ les recommandations des participants

_____

_____

_____

_____

_____

Appendix C: Codebook

Geralda Felix Codebook

Research Question	Theme	Node	Code	Example
Poverty – access health services	Barriers to health care	Transportation	Distance Barriers	4 hours to hospital
			No Cars	Taxi to city
			No transport at night	Can't find taxi at night
			No hospital or emergency room	Nearest hospital or emergency room is 4 hours away
			[EXOSYSTEM]	
		Lack Services	No ambulances	No ambulances for emergencies during the day or at night
			No pharmacies	No pharmacy nearby
			Village Clinic closes early	Village clinic closes at 4 pm
			Village clinic is understaffed	No doctor and only one nurse
			Village clinic is ill-equipped	Services offered are limited to pills and referral to the city's hospital
	Alternative to Health care	Alternative medicine	Traditional healing practices	Boil tea leafs and herbs
				Bone setting
			Vodou Priest	Consult vodou priest for health care

		Spirituality	God	Faith in God for healing
				Pray to God
				Hope in God to change situation
			[MACROSYSTEM]	
SES impacts on health	Living Conditions	Food	Malnutrition	I am struggling to find food to stay alive
			Starvation	Sometimes my whole family spent the whole day without eating
			Undernourishment	Sometimes I can't even afford breakfast to give my kids
			Hunger	The whole family stay hungry for days
			Emaciated people	I am 50 but I look older, I look bony you see because I have no food to eat to feed my body
			Unreliable food resources	When there is no crops or harvest, my family don't eat
		Money	No Money for food	I can't even put food on the table every day for my kids.

			Cannot afford an education for kids	I can't send all of my kids to school
			No money for health care needs	I avoid going to the hospital because I have no money
			Cost of transportation	Round trip transportation to the city's hospital is too much
		Socioeconomic Status	No Education	I don't know how to read or write. I did not go to school
			No employment	This village is affected by unemployment and people lack enough to live
			[MESOSYSTEM]	
		Living Conditions	Crowdedness	Seven people live in a tiny mud house with just two small bedrooms
			Homelessness	Temporarily living with someone
			Use disease-infested water	Using untreated river/canal water to drink, cook, wash, and bathe
			Lack basic necessities	Sleep on the floor, no bed. Wears same clothes for days. Walk

				around barefoot all day. Kids wearing no clothes.
			Midwife services	No prenatal/ no postnatal care/ No women's care /Only Midwife delivers baby in this village
			[MICROSYSTEM]	
	Effects of no care	Chronic stress	Living with chronic stress, anxiety, and worries.	My life is so stressful that I am losing my sanity. Being an unemployed single mom living in poverty, raising 5 kids with a 6th child on the way is very stressful.
		Chronic illnesses	Living with chronic illnesses for 3 years or more.	Migraine, Hypertension, vaginal discharge, dizziness, skin rash, joint pain/ and infections.
		Teenage Pregnancy	Unplanned teenage pregnancy is the norm because there is nothing at all to do.	I became pregnant at only 14 years old.
		Infant Mortality Stillborn Babies	No Prenatal Care No Postnatal Care No women Care	I had two kids with but they both died

				before the age of three,

Appendix D: Example of Audit Trail

Verification	**Strategy**	**Method**
Raw Data	Refers to unprocessed text	Transcribed interviews Verbatim response to interview question Digital Audio recording
Data Reduction and Analysis	Transformation of information, empirically derived, into corrected, ordered, and simplified form.	Emergent themes Research goals of study Chapter Summaries
Data Reconstruction and Synthesis	This method shows the time it actually took to complete each task. Such data have the advantages of being easy to collect, understand, and communicate.	Themes clustered into emergent categories Recommendations, and conclusion Integration of concepts, relationships, interpretations)
Process Notes	Methodological notes as they relate to procedure, design, and strategies	Trustworthiness notes Audit trail notes
Instrumentation	Researcher is the primary data collector.	Semistructured interviews

Appendix E: IRB Approval Letter

From: IRB
Sent: Friday, January 27, 2017 7:24 PM
To: Geralda Felix
Cc: Aimee E. Ferraro
Subject: IRB Materials Approved - Geralda Felix

Dear Ms. Felix,

This email is to notify you that the Institutional Review Board (IRB) has approved your application for the study entitled, "The phenomenology of women experiencing poor health through poverty in rural Haiti."

Your approval # is 01-27-17-0447000. You will need to reference this number in your dissertation and in any future funding or publication submissions. Also attached to this e-mail is the IRB approved consent forms. Please note, if these are already in an on-line format, you will need to update those consent documents to include the IRB approval number and expiration date. You will also need to ensure the Creole consent forms are updated with this information.

Your IRB approval expires on January 26, 2018. One month before this expiration date, you will be sent a Continuing Review Form, which must be submitted if you wish to collect data beyond the approval expiration date.

Sincerely,

Libby Munson

Research Ethics Support Specialist

Office of Research Ethics and Compliance