Fanm Ayisyen Pap Kase
Haitian Women Will Not Break: Humanitarian Post-Disaster Responses to Reproductive Health In Haiti

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The Faculty of the Graduate School of Arts and Sciences
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By
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ABSTRACT

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Waltham, Massachusetts

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Reproductive healthcare (RH) in Haiti has always been in a state of crisis. A country constantly challenged by political unrest or natural disasters has made access to reliable healthcare difficult. Haitian women and girls have only known inconsistent access to crucial RH services such as contraceptives, post and antenatal care and family planning resources. After the devastating earthquake in 2010, local and international non-governmental organizations as well as the Haitian Ministry of Health have been struggling to address all aspects of reproductive healthcare during the rebuilding process. In this paper, secondary interviews are used that were conducted in several camps surrounding Port-au-Prince by researchers from Human Rights Watch. Several reports were used prior to the earthquake as an assessment of the status of reproductive health services prior to the disaster as a basis of comparison to the immediate response following the quake. In a report
carried out by JSI, they found that Haiti was constantly functioning “in crisis”, therefore when the earthquake struck, the methods used to address reproductive health which were already under strain, were easily dismissed in order to address more “serious” health crises. Three years after the earthquake, there have been several advances made by both the Haitian Ministry of Health and international health allies such as Partners in Health in addressing reproductive health as well as advocating for a stronger public health system. Recognizing the direct link between women’s health and a country’s development, coordination between the Haitian government and the local and international NGOs will be the key to establishing easier access to reproductive health services and the beginning of a new chapter for Haiti’s healthcare system.
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# ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>CEDAW</td>
<td>Committee on the Elimination of Discrimination Against Women</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
</tr>
<tr>
<td>HRW</td>
<td>Human Rights Watch</td>
</tr>
<tr>
<td>IDP</td>
<td>Internally Displaced People</td>
</tr>
<tr>
<td>IFAD</td>
<td>International Fund for Agricultural Development</td>
</tr>
<tr>
<td>ISAC</td>
<td>Inter-Agency Standing Committee</td>
</tr>
<tr>
<td>MSF</td>
<td>Médecins Sans Frontières</td>
</tr>
<tr>
<td>MSPP</td>
<td>Ministère de la Santé Publique et de la Population</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Government Organization</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>Obstetrics and Gynecology</td>
</tr>
<tr>
<td>OCHA</td>
<td>Office for the Coordination of Humanitarian Affairs</td>
</tr>
<tr>
<td>PBS</td>
<td>Public Broadcasting Service</td>
</tr>
<tr>
<td>PDNA</td>
<td>Post Disaster Needs Assessment</td>
</tr>
<tr>
<td>PIH</td>
<td>Partners in Health</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>SOFA</td>
<td>Solidarité Famn Ayisyen</td>
</tr>
<tr>
<td>SOG</td>
<td>Free Obstetric Care Program</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</table>
1. INTRODUCTION

When all 193 United Nations member states and 23 international organizations came together in 2000, they established eight goals that they knew needed to be achieved by year 2015 to accelerate development across all countries. It was not until the 2005 World Summit that leaders added universal access to reproductive health as a target in the Millennium Development framework. The degree of women’s access to reproductive health is a key indicator of poverty and therefore when one fails, they all fail.

When the 7.0 magnitude earthquake struck Haiti’s epicenter of Port-au-Prince on January 12, 2010, it created complexities that even the world’s experts had difficulty navigating. Lost in the chaos that followed were the crucial reproductive health services that women are in constant need of. In an interview that a local gynecologist recounted to an international NGO, she said that she had attempted to set up an OBGYN unit in the General Hospital but was immediately turned away stating that there was no need for her services, that the space was to be used to provide care to immediate injuries.

Reproductive health is often characterized as a “cross-cutting” theme but, the urgency to which attention to reproductive health is paid lost steam in sight of what
are deemed much larger problems. Haitian women have bared the brunt of failed NGO health initiatives, government instability, as well as institutionalized sexism within the country. Lack of access to adequate reproductive health care affects poor women disproportionately than their wealthier counterparts. With over 77 percent (International Fund for Agricultural Development) of the overall population considered poor, the financial barriers preventing women from accessing reproductive health services are significantly increased.

The earthquake in 2010 exacerbated challenges that Haitian women already faced when accessing adequate reproductive health resources. Prior to the earthquake Haiti’s public health system was operating under a constant crisis framework (JSI, 2009. p. 11) therefore when disaster struck, and those frameworks were challenged and collaboration and communication were lost in effort to administer immediate relief to the injured, it left reproductive health to the wayside. This paper will explore reproductive health before the earthquake in Haiti, the immediate responses to the several components of reproductive health (i.e. gender based violence, family planning etc.) following the earthquake, current challenges that the country and institutions face three years after and finally recommendations, many that are shared amongst international organizations and finally my personal observations based on my research.
2. REPRODUCTIVE HEALTH BEFORE THE EARTHQUAKE: “Haiti is always in crisis” (JSI, 2009. p.10)

Haitian women suffer some of the most dire health conditions in the western hemisphere. The poor reproductive health care system can be identified by the female life expectancy of 63, as compared to the Dominican Republic at 72 or 81 years for women in the US (WHO, 2013). Classified as a *fragile state*, Haiti faces political, economic and social obstacles that prevent it from providing basic healthcare to its people.

A USAID report on Haiti in 2008 stated that nearly fifty percent of women in union did not want any more children and over thirty percent desire to space their next child by more than two years (USAID, 2008. p. 36). That same report found that by combining the number of women currently using a contraceptive method, overall demand for family planning in Haiti could be estimated as seventy percent (Ibid, p. 37). The high unmet need for family planning is attributed to the fact that most of the health centers are located in urban areas. As a result, rural women have difficulty accessing these resources. These numbers may be demonstrative of how Haiti’s poor family planning and health service locations most severely impact poor women. Although women are those that are responsible for all family needs and
concerns, they have the least control within the household of their reproductive preferences (USAID 2007, p. 8). This lack of agency over their reproductive rights perpetuates Haiti’s vicious cycle of poverty.

The alarming numbers for reproductive health indicators shown in Table 1 highlight just how big a challenge it has been to tackle. This numbers have remained fairly consistent over the past few decades and their severity requires consistent funding and attention, both of which have been lacking dependability. There are several reasons for this such as political, structural and donor agendas. Reproductive health in Haiti has therefore been one of those areas that are as quickly picked up as it is dropped and then left for the next group to pick it back up again.

Pregnancy and childbirth should be reason for celebration for every woman. However for many women all over the world, pregnancy and childbirth present

Table 2.0: JSI (2009)

<table>
<thead>
<tr>
<th>Selected Reproductive Health Indicators</th>
<th>Haiti</th>
<th>Dominican Republic</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (women, years)</td>
<td>62.8(^{14})</td>
<td>75.5(^{15})</td>
<td>80.8(^{16})</td>
</tr>
<tr>
<td>Maternal Mortality Ratio: maternal deaths per 100,000 live births</td>
<td>630 per 100,000 live births(^{17})</td>
<td>150 per 100,000 live births(^{18})</td>
<td>14(^{19})</td>
</tr>
<tr>
<td>Infant Mortality Rate (under 1 year, per 1,000 live births)</td>
<td>57(^{20})</td>
<td>31(^{21})</td>
<td>7(^{22})</td>
</tr>
<tr>
<td>Total Fertility Rate</td>
<td>4.79(^{23})</td>
<td>2.9(^{24})</td>
<td>2.1(^{25})</td>
</tr>
<tr>
<td>Unmet need for family planning (women 15-49 years)</td>
<td>37.5(^{26})</td>
<td>11(^{27})</td>
<td>Not available</td>
</tr>
<tr>
<td>Births attended by trained personnel</td>
<td>26.1(^{28})</td>
<td>98(^{29})</td>
<td>99(^{30})</td>
</tr>
</tbody>
</table>

Table 1: In terms of reproductive health, Haiti has fallen further behind its developing neighbor, Dominican Republic, and even further behind developed nations like the US.
serious health risks, which when left unattended, can lead to serious illness and in some cases, death. According to Ahmed Abdella, “Maternal death is an indicator of disparity and inequity between men and women and its extent a sign of women’s place in society and their access to social, health and nutrition services and to economic opportunities”. Haiti has the highest infant mortality rate, under the age of five, and maternal mortality rates in the Western hemisphere.

The Ministère de la Santé Publique et de la Population (MSPP) recognizes the critical state that their health care system is in, reproductive health in particular. Maternal mortality reduction has and still remains a top priority for the MSPP as well as large international NGOs and donors. Although overall there is a consensus on the importance of achieving safer motherhood, an obstetrician gynecologist from a large international health NGOs reported that 30% of maternal deaths in their facility are a result of unsafe abortions (JSI 2009, p. 10). Despite having a relatively accommodating policy environment for improving reproductive health in Haiti, the challenge remains with negotiating donor agendas. The MSPP’s national strategy is nearly 100% donor funded and has therefore created frustrations with ministry officials who must maintain a balance between local needs and donor motivations (Human Rights Watch, 2011. p. 20).

There have been several approaches to trying to lower the maternal mortality and improve reproductive health services in Haiti. The USAID portfolio claims to address primary challenges to maternal mortality by increasing economic and employment
stability. They also sought to increase the improved rule of law and responsive
government while at the same time increasing access to social services such as
education and healthcare (USAID, 2008. p.6). Partners in Health took a more direct
approach in training more Haitians midwives providing family planning
interventions as well as funding new clinics, which addresses the issue of family
planning and contraceptive education, accessibility and quality of health care
(Partners in Health, 2011).

Environmental catastrophes have also added to the constant state of crisis that
Haiti’s healthcare professionals are always trying to manage. Hurricanes, floods and
earthquakes have forever plagued this small island and have all contributed to the
weak health infrastructure. A JSI report points out that in comparison to other
sectors, health in crises is often neglected (JSI, 2009. p. 8). In an OCHA flash appeal
in response to the 2008 hurricanes, health represented only 4% of the total request

The majority of the responding NGOs and humanitarian relief organizations, while
capable of providing services during crisis, cannot meet the demands for long-term
health needs. Often in Haiti, there will be a crisis that will draw hundreds of health
workers, however due to several factors, mainly infrastructure and finances,
implementation of sustainable health programs fail.
2.1 Haitian Reproductive Health Statistics Before the Earthquake

Haitian women are seventy times more likely to die than their American counterparts during childbirth, merely a two hour plane ride away (PBS, 2010). According to international health experts, the easiest way to dramatically decrease maternal and infant mortality rates is to increase access to contraception and family planning information. In a review and assessment of USAID/Haiti Maternal and Child Health and Family Planning Portfolio, it states that, “the fundamental determinants of poor health status in Haitian women and children are extreme poverty, poor governance, societal collapse, infrastructural inefficiency, and food insecurity” (USAID, 2008. p. 6).

Table 2.1

![Graphs showing under-five mortality rate and maternal mortality ratio](http://www.countdown2015mnch.org/documents/2012Report/2012_Haiti.pdf)

The Millennium Development Goals set forth following the Millennium Summit in 2000 by the United Nations, highlight a great challenge for Haiti under goals 4 and 5, which call for reducing child mortality and increasing maternal health by 75 percent by 2015. Since 2005, the under-five mortality rate has increased from 95 to 165 per
1,000 live births (Table 2). Much of this increase is brought on by poor nutrition, which is in most cases attributed to extreme poverty. The maternal mortality ratio, however, has been steadily decreasing since 2005 and since 2010 was at 350 deaths per 100,000 live births but is not projected to meet its target of 150 deaths per 100,000 live births by 2015 (Countdown to 2015, 2012. p. 1).
3. REPRODUCTIVE HEALTH AFTER THE EARTHQUAKE

On January 12, 2010 at 4:53 pm a magnitude 7.0 earthquake ripped through Port-au-Prince and surrounding towns. Concrete buildings wavered and crumbled to the ground claiming the lives of those who could not reach the exit fast enough. Chaos took over the major city that hosted a population of nearly 705,000.

We now know that in those few moments, nearly 200,000 lives were lost and countless were left injured. To compound this tragedy, the earthquake flattened more than 50 hospitals and clinics as well as claimed the lives of several of Haiti’s few trained doctors and nurses (The Government of the Republic of Haiti, 2010. p. 5). A total of sixty percent of health facilities were damaged and 10 percent of health professionals were killed or emigrated immediately following the earthquake (Human Rights Watch, 2011. p. 21). Prior to the quake, Port-au-Prince served as the hub of the majority of Haiti’s healthcare system. Throughout the upcoming months, the impact of this devastation is critical to understand just how frustrating the process of obtaining information and maintaining effective coordination was and will continue to be for those working in health reconstruction in Haiti.

In the days, weeks and months following the earthquake, over 400 health NGOs participated in the health cluster put together by the UN’s Office for the
Coordination of Humanitarian Affairs (OCHA). The use of a cluster system is crucial for all humanitarian actors to coordinate critical needs such as health, nutrition, water and sanitation. Many believed that the quantity of health NGOs then present in Haiti would improve the quality of the health system. However almost 9 months after the earthquake, a study found that only 20 percent of displacement camps had any kind of health care facility on site (Schuller, 2010. p. 4). Following the earthquake there were several obstacles women faced in accessing adequate reproductive healthcare. Women who were pregnant at the time of the earthquake faced additional challenges in seeking care than ever before. For them, finding medical attention before and after childbirth proved to nearly cost them their lives.

3.1 Maternal Health in Displacement Camps

We underestimated the impact of time before responding. We didn’t prioritize women’s health at the beginning of the response. None of the big international agencies who came in for the health response had Ob/Gyns. We tried to set up a maternity ward in the General Hospital – we were pushed out by an international agency because they wanted to use the area to treat trauma victims. They said we didn’t need this now and stopped us. (Meyers et al, 2011. p. 14)

Leading Haitian Obstetric Gynecologist, Port-au-Prince

By May 2010, four months after the earthquake, it was estimated that more than 2 million individuals remained displaced in settlements within earthquake-affected areas (Camp Coordination and Camp Management Cluster in Haiti, 2013). As of January 2013, according to the same tracking matrix, an estimated 347,284 individuals remain in 450 IDP sites resulting in a decrease of 77% in overall IDP
population since 2010 (Ibid, 2013). Although the numbers demonstrate an overall decrease, there are some slight population increases in certain camps. It is possible that these increases are indicative of the severe lack of access to information about family planning, lack of access to a health care professional as well as an increased number of cases of rape.

According to a report done in 2011 by Human Rights Watch, compiled through a series of individual and group interviews with girls and women in displacement camps, 66 percent of all pregnancies in the displacement settlements were unwanted or unplanned. Pregnancy rates in camps for displaced people are three times higher than urban rates of pregnancy before the earthquake (Human Rights Watch, 2011. p. 24). This kind of pregnancy bubble is not uncommon for post-natural disaster countries and according to the women and girls that Human Rights Watch interviewed, a few factors were identified that led to their pregnancies. These include “A desire to compensate for the loss of a child in the earthquake; the hope of strengthening a relationship with a new partner; and a lack of access to information or to methods of contraception. A number of those interviewed also reported rape as the cause of their pregnancy” (Ibid).
3.2 Lack of Access to Information

Nobody told me about planning, but if I knew planning, I would use it. It's only I don’t know. – Tamara age 17

Prior to the earthquake, girls and women relied heavily on social networks to learn about family planning and pregnancy. The earthquake separated entire communities and families, often times leaving individuals alone in a region they were unfamiliar with, fending for themselves for the first time in their lives (Bookey & Davis 2011, p. 54).

In several interviews carried out by Human Rights Watch in 2011, Haitian girls and women in camps expressed the need for more information regarding family planning and contraception but many also indicated misinformation regarding contraception.

- There was no information available in the camps where they lived;
- Information on family planning was given at prenatal checkups and therefore too late to prevent pregnancy; and
- Information about side effects, proper usage, and when to begin postnatal family planning was either unavailable or incorrect.

The lack of information or access to information in these camps is discouraging considering the number of health organizations in Haiti who have stated that attention to reproductive health is a main priority. Unfortunately the majority of the hundreds of health NGOs currently registered in the country have not adhered to
the country’s reporting system so there is really no way of knowing who is not doing what they have stated that they would accomplish (Human Rights Watch, 2011. p. 64).

3.3 Access to Contraception

Difficulty accessing contraception is especially common for women still living in displacement camps. Immediately following the earthquake there was a major increase in condom distribution among the displacement camps by international NGOs. Unfortunately due to lack of funding or poor distribution, condoms are now no longer as accessible as they were in the months following the earthquake. Currently, if individuals wish to receive condoms, they must either go to a hospital or possibly receive them from an NGO, however they must now purchase them (Meyers, J., Chynoweth, S., Amsalu, R., 2011. p. 5).

Barriers such as cost of contraception and cost of transportation to a hospital are such that condom use among the camps is minimal which can lead to the spread of STDs as well as causing unplanned pregnancies. In addition to lack of access to contraception, there are several instances where women and girls do not use, or have stopped using contraceptives because of health concerns most commonly due to misinformation (Human Rights Watch, 2011. p. 29).
3.4 Illegal and Unsafe Abortions

The performance of abortions in Haiti is still considered illegal under Article 317 of the French Penal Code of 1810. Any person who performs an abortion, or any pregnant woman who attempts to perform her own abortion is subject to imprisonment. The only circumstance in which an abortion is allowed is when the mother's life is at risk; however there are reported incidences where abortions have also been performed in cases of rape, incest or of fetal impairment (Population Division, 2010).

In the 2009 Concluding Observations, the CEDAW report raised their concern for the frequent use of abortions as a means of birth control. They called for the government to develop more comprehensive measures to improve women's access to health care – specifically to reduce Haiti’s high maternal mortality rate. They noted the severe lack of female and male contraceptives in rural areas as a serious threat to women and girls' health. The Committee also recommended that the State party move forward in the partial decriminalization of abortions (CEDAW, 2009. p. 8).

But decriminalization has not happened since the earthquake struck. Despite the penalty of breaking this law, with as many as 66 percent of all pregnancies in displacement camps that were unplanned or unwanted, many women resort to various abortion methods to terminate the pregnancy (Human Rights Watch 2011,
p. 32). Some use various herbs or teas even a mixture of salt water and frozen Coca Cola were mentioned, however the most common drug used is misoprotosol.

Prescribed to treat gastric ulcers and to induce labor, misoprotosol is available on the street market and is the cause of many of the abortion complications that clinicians witness (Ibid, p.33).

\[\text{We see a lot of [cases of complications due to] abortion, both from Cytotec [brand name from misoprotosol] and instruments. This is a big problem for women's health. Women come in with infections that are dangerous. (HRW, 2011. p. 33)}\]

Nurse Caillot, head nurse at Chancerelles

Although the Chancerelles hospital could not provide exact numbers for women who had come to them with complications from unsafe abortions, nurses and doctors have noticed a significant increase in cases in months following the earthquake (Human Rights Watch, 2011. p. 32). Several other hospitals in the Port-au-Prince area reported receiving an increased number of patients coming in presenting complications of unsafe abortions (Ibid, p. 34).

\[\text{3.5 Accessing Prenatal Care}\]

The obstacles preventing women and girls from accessing prenatal care were significantly exacerbated after the earthquake. The barriers present before the natural disaster were high, however thanks to several health initiatives such as the Free Obstetric Care project (SOG) and free services from Médecins Sans Frontières (MSF) some women were able to access safe services.
The most prevalent challenge to seeking prenatal care for Haitian women is lack of knowledge related to the need of care, where to access it, and economic barriers not directly associated with the cost of a prenatal check-up, such as transportation and sonogram costs (Human Rights Watch, 2011. p. 35).

The earthquake destroyed many of the clinics and hospitals that these women had perhaps once used during their previous pregnancies, and now, living in an unfamiliar neighborhood, they did not know where to seek care. A doctor interviewed by Human Rights Watch with years of experience said:

The earthquake destroyed social systems and many of the physical reference points for communities disappeared: churches, small clinics, etcetera. People moved to new neighborhoods and the geography was completely changed. They didn’t know what existed before, what clinics or hospitals, or what is available now. The daily struggle in the camps is difficult, and families can’t foresee their health needs in the future. When the need arises, people don’t know where to go. They ask other people, and most only know the general hospital, which is too far and has a reputation for lacking drugs or doctors.” (HRW, 2011. p. 36)

Economic barriers to seeking prenatal care are also common. Even if women wanted to seek out prenatal care, often times they would have to walk several kilometers to reach the nearest clinic because they could not afford the transportation cost. Additionally, some women discontinued their prenatal visits because of the cost of prescribed sonograms. Several women incorrectly thought that they could not
return to see a physician without the sonogram, so to avoid this, they went to multiple clinics resulting in higher transportation costs.

Despite initiatives led by international health organizations such as MSF and the Haitian Ministry of Health’s Free Obstetric Care Project to remove economic barriers upon arrival, there are clearly costs that still remain as large impediments for women seeking prenatal care.

**3.6 Challenges Accessing Obstetric Care**

Before the earthquake, access to obstetric care was extremely limited, and today access to obstetric care is even more difficult and sometimes impossible. Skilled birth attendants are rare and far between and to make matters worse, during the earthquake the clinic training a new wave of midwives collapsed killing nearly all (UNFPA, 2010).

Of the 75 women that Human Rights Watch interviewed, over half of them had given birth since the earthquake either in the camps or for some others, on the street on the way to a hospital without a skilled birth attendant (HRW, 2011. p. 41). Among them, there was an overwhelming preference to have had given birth in a hospital. Eighty-seven percent of pregnant women living in camps expressed the same preference to the UN Population Fund (L’Institute Haïtien de l’Enfance, 2010. p.75).
When attempting to identify the obstacles to accessing obstetric care, humanitarian organizations will often times find evidence of what is called “the three delays”. The three delays are:

1. Women did not seek appropriate care because of a lack of recognition of the signs of labor and other information
2. Women did not reach appropriate facilities because of distance, concerns about security, or transportation costs
3. Women did not receive adequate care when reaching a facility because they could not afford the cost of care or the facility lacked resources (Human Rights Watch, 2011. p. 41).

The three delays were developed as a way of understanding the various components that hinder women’s access to maternal healthcare, but also as a way of identifying areas that need attention to prevent further unnecessary maternal deaths. Not recognizing early signs of labor is especially risky and can potentially put mothers in unnecessary, vulnerable situations.

I was in labor for a day. I was at home first, but I knew to go to the hospital when I felt my bellyache. The doctor talked to me about the signs of labor and to go to the hospital. The head of the child was outside of my vagina when I got to the hospital.
   – Carlene 28 (Human Rights Watch, p.42)

Carlene was lucky to have not had any complications during her journey to the hospital. Had Carlene’s doctor educated her on the early signs of labor, her birthing experience may have been much less traumatic and safer. The first delay can be the
most deadly, not recognizing the early signs of labor could have cost Carlene her life had she experienced any complications.

### 3.7 Adequate Data Collection

In interviews with several health care providers throughout Haiti, few were able to provide exact numbers of maternal deaths in their facilities (Krause, 2011. p.15). In an inter-agency report on reproductive health conducted in Haiti in 2011, the indicators used in the Internally Displaced Surveillance System that both the MSPP and PAHO use included those that refer specifically to reproductive health such as the number of pregnancies seen with complications, third trimester pregnancies without prenatal care and, the number of patients with interrupted antiretroviral therapy (Ibid, p. 18).

Lack of adequate or accurate data has been a serious challenge for the Haitian government as well as local and international organizations that are currently making attempts to create a semblance of a centralized data system. The problem arises in attempts to identify areas in reproductive health that are or are not being met and who is and is not carrying out their expected mission in administering those services.
### 3.8 Impact of Food Insecurity on Reproductive and Maternal Health

Food insecurity is a major concern that affects all IDPs in displacement camps, however this challenge is felt most harshly by pregnant women and girls and lactating mothers. Reports carried out by Human Rights Watch (2011) and MADRE (2011) have found that food insecurity has led some vulnerable women to participate in informal transactional sex. This high-risk activity exposes women and girls to higher rates of sexually transmitted diseases, unwanted pregnancies as well as the potential to be victims of violence.

Prior to the earthquake, between 28-38% of Haitians were considered acutely food insecure (IASC, 2010. p. 6). These pre-existing vulnerabilities have acted as one of the greatest challenges for the humanitarian community when looking to address food insecurity for the most vulnerable. When nearly 52% of all households in Haiti are considered to be food insecure, establishing who is “most vulnerable” becomes a nearly impossible metric.

Immediately following the earthquake, Haiti was overcome with the number of international aid organizations providing food assistance. Nearly 4 million people received food assistance within the first six months (ISAC, 2010. p. 1). According by a report by the Inter-Agency Standing Committee (IASC), within six months of the earthquake, over 500,000 children between 6-59 months and pregnant and lactating women have received ready-to-use supplementary food and
approximately 23,000 mother-baby pairs have benefited from breast-feeding counseling (Ibid, p. 13). High food insecurity contributes directly to the risk of complications during pregnancy as well as childhood illness (USAID, 2008. p. 58).

Two years after the earthquake, Human Rights Watch (HRW) found that women and girls still living in displacement camps have often had to resort to transactional sex to feed both themselves and their children.

"People will try to survive by the way they can. Women have relationships with men so they can feed their children. That happens a lot. My daughter is 12 and does not have friends in the camps, because it happens that even girls are pressured to have sex for things. I don’t work. I don’t have parents to help. Many times women get pregnant, and they don’t have anyone to take care of them. So, for US$0.60 or $1.25, you have sex just for that. Unfortunately, women sometimes get pregnant, but if we had access to planning, we’d protect ourselves…it’s not good to make prostitution, but what can you do? You have to eat." (HRW, 2011. p. 51)

In commercial sexual transactions, men pay higher prices for sex without condoms. However, in the informal exchanges, it is very difficult for women to negotiate condom use with partners. This drastically exploits women’s vulnerabilities to be subjected to violence, rape and disease. In addition, the majority of these transactions are done in private, therefore removing women and girls from the security they may have had available from social networks or the community (HRW, 2011. p. 31).
3.9. Gender Based Violence in Displacement Camps

“Sometimes we have to sleep with one eye open” – Rosette, 40
(HRW, 2011. p. 52)

For girls and women, life in Haiti’s displacement camps is one of constant fear and anxiety. These sentiments are absolutely founded given the level of insecurity within the camps. Despite the billions of dollars being poured into the country for recovery, aid efforts have struggled to meet the basic needs of people living in IDP camps (RNDDH, 2010. p2).

Displacement and poverty put women and girls in increasingly dangerous situations making them vulnerable to sexual violence. There are several factors that contribute to this increased violence including inadequate shelter (many of the tents are simple tarps without zippers or ones that can be easily slashed with a knife), lack of privacy and security in the bathrooms and showers, as well as lack of adequate lighting at night. In addition, many girls have been left without families or any kind of adult protection and are forced to live with friends. Lack of community or familial protection increases women and girls’ exposure to GBV.

Prior to the earthquake, approximately 26 percent of women and girls have reported being victims of sexual and gender based violence (Office of the Secretary General’s Special Advisor, 2010). Despite a lack of exact data, several institutions have stated that the number of cases of rape and GBV have increased in displacement camps. In an inter-agency report on the status of GBV in displacement
camps, several of the survivors of rape that they interviewed stated that they were assaulted by two or more individuals almost always armed with guns, knives or other weapons. Through the interviews, it was clear that the perpetrators were attacking primarily to perpetrate sexual violence, as only a few interviewees reported other crimes such as robbery (MADRE, 2011. p. 11).

Rape in Haiti was only made illegal in 2005, and marital rape is yet to be recognized. Therefore, when the earthquake hit, it compounded already shaky gender relations and plunged women and girls into an environment not suitable for their health or spirits. Justice for rape victims is nearly impossible for two distinct reasons: lack of access to legal services and unwillingness of police to respond (MADRE, 2011. p.13). Additional factors that may inhibit a woman's ability to seek justice is her own fear of retaliation or of social stigma.

Sexual violence can have serious physical and mental consequences for women and girls. Several of the women interviewed for a report done by MADRE's Lisa Davis showed signs of post-traumatic stress disorder, including extreme fear, nervousness, helplessness, inability to sleep, nightmares, and signs of depression. Female victims are not the only ones affected by this form of violence, the children, sometimes forced to watch the rape of their mothers, often times will exhibit these similar signs of trauma similar to their mothers (Bookey & Davis, 2011. p. 55).
3.10. Adolescents

We don’t need handouts; we need jobs, specifically for the college graduates and head of households.

-Adolescent male focus group discussion participant, Martissant, Port-au-Prince (Meyers et al. 2011. p. 5)

Adolescents tend to be the most neglected group in terms of development projects, and especially during reconstruction periods such as the one Haiti is currently experiencing. The unmet needs for Haitian adolescents (ages 12-19) is staggering with the lack of basic necessities being the largest challenge. An inter-agency assessment report carried out by several NGOs such as CARE and Save the Children found through various focus group discussions in 2011 that both adolescents and adults felt that sexual activity among adolescents was on the rise, enhancing the risk for STIs and unwanted pregnancies. Consistent with several other reports, access to birth control such as condoms were irregular either there were none available or so low a supply required condoms be purchased.

During these focus group discussions, the facilitators were made aware of the prevalence of boys buying sex for small sums of money from girls. These girls stated that they were concerned for their safety in the camps, and requested jobs as a way to prevent having to exchange sex for commodities.

By not making reproductive health a priority in the initial response to addressing Haitian women’s needs, it has elevated their vulnerabilities both in terms of mental
and physical health. It seems that now organizations and the Haitian ministry are in a position of playing catch up while women and children are to wait even longer.
4.0 CURRENT CHALLENGES

In any country where a disaster such as the earthquake in Haiti occurs, it is the government’s responsibility to lead the recovery response. Unfortunately for the case of Haiti, the Haitian government has neither the political nor the economic capacity to fulfill its responsibilities to its people.

As a result, much of the recovery responses have been spearheaded by international NGOs with only occasional consultation with local health leaders. In March of 2010, the government of Haiti published a Post Disaster Needs Assessment (PDNA) in which special attention to maternal and reproductive health was made. There was a call for a special integration of these health needs with other health protocols that were being carried out by international organizations.

Acknowledging their major lack of human resources both in terms of quantity and quality, the Haitian government is dependent on international organizations and NGOs to fund and implement their plans (Government of the Republic of Haiti, 2010. p. 60).
4.1 Donors and Non-Governmental Organizations (NGOs)

On March 31, 2010 at the International Donors’ Conference on the New Future for Haiti, U.S. Secretary of State Hilary Clinton highlighted the importance of a new way of approaching aid in Haiti. “We also have to pledge our best efforts to do better ourselves – to offer our support in a smarter way, a more effective way that produces real results for the people of Haiti.” (Clinton, 2010). The outpouring of money from international community was astounding. With more than $5.2 billion total in emergency relief private donations reached around $1.4 billion in the United States alone (UN Office of the Special Envoy for Haiti, 2011).

The challenge was how were international institutions planning on changing their strategies for how they administered aid so that they would not end up in disastrous situations as they had many times before. Aid in Haiti has a long and painful history; some even claim that it is aid that has permanently crippled the country. In Jonathan M. Katz’s book The Big Truck That Went By: How the World Came to Save Haiti and Left Behind a Disaster, he uses his own personal and friends’ accounts supplemented with research to clearly outline how much the current disaster relief efforts have gone completely awry, leaving behind a “legacy [of the response that] has been a sense of betrayal” (Katz, 2013. p. 2). This sense of betrayal is paramount to understanding how years of undelivered promised aid has affected relationships not only between the Haitian government and international community, but also that of the Haitian people and the rest of the world.
In a rather scathing article published in *The Nation* in 2012, authors Polman and Karreich paint a distressing image of how Haiti is faring almost three years after the earthquake, still waiting for over $2 billion in aid. The name NGO Republic is not meant to be a flattering one, but has nevertheless served as a realistic depiction of who has been guiding Haiti's development over the past several decades. This culmination of years of inconsistent aid reaches a head in 2013 where this article critiques this method of development as the motivations of donors are far too volatile and unreliable for a country still in the fragile state of recovery.

One of the final insults experienced by almost any NGO Republic is that its donors decide not only where and how the money will be spent but also when it is no longer needed— which is what is happening in Haiti now. Aid is drying up. Though the international community has delivered just a bit more than half of the $5.3 billion originally pledged to Haiti—52.3 percent as of the end of September—there doesn’t seem to be any plan to make up the difference. Only 52 percent of the $300 million the UN and its partners requested to cover humanitarian aid in 2011 was funded. The figures for this year are worse (Polman & Klarreich, 2012, para 43).

For the past several decades, donors and the Haitian government have fostered a tumultuous relationship. Donors have been reluctant to support the government directly for several reasons; one mainly being that of a history of corruption and lack of specificity in plans. When former Haitian president Aristide narrowly won his second term (2000-2004), the United States cut off all aid to the country in protest of the election results. Haiti’s instability has strongly discouraged past and future investment and involvement from international governments and donors.
Recognizing their challenging reputation, following the earthquake, the Ministry of Health (MSPP) elaborated upon the findings of the needs assessment and the national plan for recovery and designed an interim and comprehensive plan for the health sector (Human Rights Watch, 2011. p. 66).

The idea was to create a network of all the health NGOs that were entering the country and develop a streamlined referral system so that coordination among the many working members could function most effectively. Six months after the March 31, 2010 Donor’s Conference, much of the original emergency response coordination fazed out as new plans for a long-term Haitian health care system came into development. During the interviews carried out by members of the Human Rights Watch team, they continuously ran into the common sentiment among NGOs and Haitian government officials that there was, “still a tendency for NGOs and donors to do things their way” (HRW, 2011. p.64).

The government, as a member of the health cluster, tried to coordinate the arrival or new medical NGOs. It established an online registration form, and has over 400 registered medical NGOs. It also created reporting guidelines for NGOs; however, as of February 2011, of these 400 registered NGOs, only 14 had filed reports with the health ministry as requested (HRW, 2011. p. 64).

This lack of data is detrimental to the future coordination of health efforts by other NGOs and especially by the Haitian government. There is no means to assess progress or identify areas for improvement if all actors are working more or less independently from the government.
Additionally, donors play an integral role in what kinds of policies are developed in Haiti. Despite a relatively positive atmosphere for increasing safe motherhood, particularly with the MSPP’s comprehensive strategy, donor enthusiasm has not followed suit. Prior to the earthquake, nearly 100% of the program set out by the MSPP was donor funded (HRW, 2011. p. 20). This caused tension and frustration among health care practitioners who are now charged with not only trying to provide basic health services, but also adhere to donor agendas (Klarreich & Polman, 2012. para 7).

4.2 MSPP Response to Reproductive Health During Reconstruction

According to the 2012 Poverty Reduction Strategy Paper released by the Haitian Ministry, in the past the health sector has only received approximately 10% of funding from the overall budget, which was used primarily for operating costs and less than 1% for investment for future health sector needs (IMF, 2012. p. 29). The report acknowledges the extreme need for the reallocation of national budgets, particularly in terms of investment spending to carry out the programs that more directly affect disadvantaged groups such as poor women (Ibid, p. 29)

Among several other health indicators, the maternal mortality rate, infant mortality, HIV/AIDS prevalence rate among pregnant women between 15-24 years old and the percentage of women infected with HIV/AIDS are listed. The MSPP has established a steady supply to 80 percent of institutions of drugs, materials and inputs for treating complicated diarrhea, systematic weighing of children 1 to 4 years old. The
MSPP has also set up 61 contraception distribution posts, and has held nine mobile clinics per quarter to “offer long-lasting methods” (IMF, 2012. p. 59).

The lack of attention to issues concerning gender based violence and lack of information on the issue in the Poverty Reduction Strategy Paper published in 2012 by the IMF is alarming and also seems to prefer to acknowledge reproductive health as a sub-topic more worthy as an indicator than something worth tackling head-on as a priority.

In acknowledgement to Haiti’s serious gender inequality, there is a call by the IMF for the implementation of Gender Mainstreaming in the development of new public policies. In this report done by the IMF, they have set broad expectations for gender equality policies and that overall status of women will be improved (IMF, 2012. p. 69). It is however, their section on Brief Accomplishments that raised concerns, particularly in that there do not seem to be any long-term solutions to the economic boundaries and social issues preventing women from participating in the Haitian economy. There is mention of a housing center that was established to offer hospitality services to female victims of violence which houses 20-25 women per week. In 2012 sexual assaults in the camps in Port-au-Prince were reported to be nearly 20% higher than elsewhere in Haiti (Kolbe & Muggah, 2012). Housing 20-25 women per week is not enough, and does not address the root cause of violence against women in Haiti. It particularly does not mention the complexities of
individuals who are still living in the displacement camps, 3 years later, after the earthquake.

The omission of the word “reproduction” in the 138 page Poverty Reduction Strategy Paper is concerning. Maternal health was mentioned several times, particularly in regards to achieving the MDGs, but the other crucial components to reproductive health such as GBV, family planning and quality of health care, are not satisfactorily addressed. Women’s reproductive health has always been a strong indicator for the level of poverty within a country. While addressing the high maternal mortality rate in Haiti is a very important mission, all the other components must be incorporated if women are to thrive.

4.3 Positive Stories of Capacity Building for Local Actors

The sheer volume of NGOs, in particular, health NGOs, currently operating in Haiti poses both promise and challenges for the development of a strong health sector in the future. Three years after the earthquake, funding is quickly drying up and several of the NGOs that had initially landed in Haiti after the earthquake are either significantly scaling back their operations or leaving the country (Chaggar, 2011). Immediately after the earthquake struck, the international women’s human rights organization, MADRE, contacted their sister organizations in Haiti. In partnership with local NGOs such as KOFAVIV, Zanmi Lasante, and SOFA, MADRE:

- Supported emergency medical relief and delegations of hundreds of doctors, midwives and nurses
• Established mobile clinics that treated more than 50,000 patients
• Provided life-sustaining supplies to over 1,000 women who lost their homes and possessions
• Campaigned at the UN Haiti Donors’ Conference for a reconstruction process that is Haitian-led and upholds women’s humanitarian rights
• Improved security for displaced women and advocated for an effective international response to the rising rates of sexual violence (MADRE, 2010).

MADRE’s partnerships with local organizations promises sustained attention to Haitian women’s need for access to better reproductive healthcare. Additionally, their conviction that taking the human rights based approach to rebuilding Haiti is the only way to ensure that women in Haiti will be able to have access to resources that will release them from the poverty stricken livelihoods of which too many are prisoners.

KOFAVIV is a Haitian organization built by and for survivors of rape. Their work has become crucial during the past three years, as reports of rape and sexual violence within internally displaced persons camps have increased significantly. A study done by the Center for Human Rights and Global Justice found that 14% of households reported that at least one member of the household had been a victim of sexual violence since the earthquake (2012, p. 1). SOFA (Solidarité Fann Ayisyen) is one of Haiti’s largest women’s organizations that also offer resources to women who are victims of rape or sexual violence. Offering 21 centers and safe houses prior to the earthquake, SOFA continues to advocate to the end of violence against women
and justice to their perpetrators (Haitian Women Network, 2010). Finally, Zanmi Lasante, a sister organization of Partners in Health, has prioritized women’s access to healthcare since its inception in 1985.

Partners in Health, a long time partner of Haiti, has plans to open the largest training hospital in the country. Located some thirty miles outside of Port-au-Prince, the soon-to-be opened public hospital was imagined and designed with the people’s needs in mind. When it is completed it will have seven buildings, 320 beds, a high-tech operating theater, even a koi pond (Polman & Karreich, 2012. para 39).

A local private clinic called Profamil continues to offer crucial reproductive health care services such as family planning, early detection of breast and cervical cancer, pre-and-post natal services, youth programs, and voluntary counseling and testing for HIV/AIDS in Port-au-Prince, Jacmel, and Port-de-Paix (IPPF, 2013). But Profamil is struggling. They have an annual budget of $1.3 million, which they have managed to stretch to the limits every year since the earthquake (Pierre-Pierre, 2013). Profamil has managed to maintain their reputation as a safe and affordable private clinic, and when asked, women who have used Profamil’s services will generally recount having a positive experience there. However due to a tightening of the budget, trying to keep up with increasing demand and keeping morale high, it is difficult not to cut corners (Ibid, 2013).

There have been hospitals and clinics built by international organizations before, but are rarely made public establishments. Many NGOs prefer to keep their
institution private for several reasons, however the main reason is less government “meddling”. It is easier for new private clinics and hospitals to pop up around the country, but it is therefore very difficult then to hold these NGOs accountable for any mishaps or complications. By opening such a large public hospital in Haiti, Partners in Health has potentially started the momentum in which the international community will begin allowing capacity growth and accountability for the government of Haiti – a much-needed step for recovery.
5. RECOMMENDATIONS

1. Women's health should be prioritized before during and after disasters.

2. Create opportunities for employment to combat transactional sex within IDP camps: Opportunities to gain a small income during times of emergency are crucial for girls and women in avoiding becoming victims of rape, gender based violence as well as unwanted pregnancies.

3. Allocate more government funding for reproductive health services before during and after natural disasters: The Haitian government as well as donors should allocate funds to a pool reserved for reproductive health services before during and after crises to ensure maintained attention to RH issues. This is especially crucial to populations living in rural areas since those are the most vulnerable and ignored communities.

4. Establishing protocols for funding mechanisms that reflect a balance between short and long-term needs: It is not realistic to assume that international aid and donations will cease to help spur national programs and initiatives, however if Haiti hopes to one day become a self-sustaining nation, the time is now to begin supporting its own programs. With less than
1% of investment expenses to show for, the Haitian government must re-evaluate.

5. Support local NGOS through establishing coordinated response system:
   There is ample research done on establishing an effective emergency coordination response system. One of which that may be most effective during times of crisis is that of a mobile crisis response system.

6. Invest in local community health infrastructure: This will lessen the burden on general hospitals as well as decrease the time, energy and money involved in the tumultuous journey that women must make to clinics to ensure medical attention.

7. Support more holistic approach to addressing reproductive health: Pay equal attention to issues of gender based violence, adolescent health and family planning.

8. Address the issue of women’s political participation: Currently women represent 13% of Senate and 4% of lower chamber (Office of the Secretary General, n.d.). There has been some movement on adopting a quota of 30% female representation in the government, however it has been a long process to gain momentum. Barriers preventing women’s participation include lack of a formal education as well as societal discrimination against women.
9. The government needs to invest more in the human capital formation of its youth: Investments in adolescents as a strategy for achieving MDGs (p. 9)

Agencies offering health services should ensure that issues of concern to adolescents, including lack of recreational and income-generating activities, opportunities for education and risk factors for all forms of sexual violence, are addressed. Use adolescents to mobilize in promotion of health and well being.
6. CONCLUSION

Three years after the earthquake and Haiti’s healthcare system is still devastated. The majority of the reproductive health care services that are available are being administered by international NGOs, who are slowly pulling out of the country as every month passes for lack of funding.

Donors are frustrated that not much impact seems to have been made in the aftermath of this catastrophic event. The slowness of outcome in terms of reforming a long broken system has deterred donors and as is the lifecycle of disaster relief initiatives, they have moved on to the next pressing catastrophe.

This is not to say that the lagging improvements to the Haitian government addressing issues concerning reproductive health are completely the fault of donors, there have been several crucial missteps. Joan Arnan, Médecins Sans Frontière’s head of mission in Haiti had this to say, “The transition process is much too slow. That’s because Haitian institutions are weak, donors have not kept their promises, and the government and the international community have failed to set clear priorities” (MSF, 2013. para 3).
The government of Haiti does not have time to wait for the international donor community to reconvene for a better funding strategy. With what monetary and human resources they currently have, investing in reproductive health care programs and establishing public clinics are the first steps for Haiti in ameliorating dismal health standards. As it will be repeated time and time again, when women’s health is made a priority, households and communities thrive. If Haiti is to thrive, it must bring on new female leadership, women who recognize the resiliency of their sisters but also the necessity to take care of one another.

Tapping into international expertise and allies such as Partners in Health will be crucial in the next few months for Haiti. Establishing a solid public health system, a mission for PIH, has the potential to give Haiti’s health care system new life. The time is now to invest in these projects before another disaster occurs. Haitian women are and will continue to be the strong backbone of a country that is ready to flourish on its own.
BIBLIOGRAPHY


