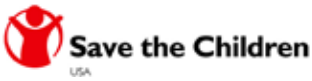
Priority Reproductive Health Activities in Haiti

An inter-agency MISP assessment conducted by CARE, International Planned Parenthood Federation, Save the Children and Women's Refugee Commission

February 2011



Acknowledgments

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Acronyms & Abbreviations

ARV	Anti-retroviral
BEmOC	Basic emergency obstetric care
CCCM	Camp coordination and camp management
CDC	Centers for Disease Control & Prevention
CEmOC	Comprehensive emergency obstetric care
EC	Emergency contraception
EmOC	Emergency obstetric care
FGD	Focus group discussion
GBV	Gender-based violence
GUS	Genital ulcer syndrome
IASC	Inter-agency Standing Committee
IAWG	Inter-agency Working Group
IDP	Internally displaced person
IDPSS	Internally Displaced Persons Surveillance System
IEC	Information, education, communication
INGO	International nongovernmental organization
IPPF	International Planned Parenthood Federation
IRC	International Rescue Committee
IUD	Inter-uterine device
MDM	Medécins du Monde
MISP	Minimum Initial Service Package
MSPP	Ministry of Public Health and Population
NGO	Nongovernmental organization
OCHA	Office for the Coordination of Humanitarian Affairs
PAC	Postabortion care
PAHO	Pan American Health Organization
PEP	Post-exposure prophylaxis
PEPFAR	(U.S.) President's Emergency Plan for AIDS Relief
PHC	Primary health care
PIH	Partners in Health
PMTCT	Prevention of mother-to-child transmission (of HIV)
PSEA	Prevention of sexual exploitation and abuse
RH	Reproductive health
RHRC	Reproductive Health Response in Crises (Consortium)
SEA	Sexual exploitation and abuse
STI	Sexually transmitted infection
TBA	Traditional birth attendant
UDS	Urinary discharge syndrome
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	UN Population Fund
UNICEF	UN Children's Fund
VDS	Vaginal discharge syndrome
WHO	World Health Organization

Executive Summary

The January 12, 2010 earthquake measuring 7.0 on the Richter scale caused massive loss of life, injuries and displacement in Haiti. In any humanitarian crisis, certain priority reproductive health (RH) services must be put in place from the earliest days of the emergency. These essential activities are defined in the Minimum Initial Services Package (MISP) for RH—an international standard of care as articulated in the Sphere *Humanitarian Charter and Minimum Standards in Disaster Response* and the Inter-agency Standing Committee *Health Cluster Guide*. The MISP includes activities to prevent sexual violence and provide care for survivors; protect against the transmission of HIV; ensure emergency care for pregnant women and newborns; ensure contraceptives, antiretrovirals and care for sexually transmitted infections (STIs) are available; and lay the groundwork for comprehensive RH services as the situation permits.

Led by the Women's Refugee Commission, an interagency group comprising CARE, the International Planned Parenthood Federation (IPPF) and Save the Children undertook a mission to Haiti in May 2010 to assess the progress the humanitarian community has made in the implementation of the MISP in emergency response operations. The assessment took place four months after the earthquake and included visits to displacement settings in Port-au-Prince, Léogâne and Jacmel.

Unlike in prior emergencies, the RH needs in Haiti were extensively highlighted from the initial days of the earthquake. Influential policy documents from the World Health Organization (WHO) and the Inter-agency Standing Committee (IASC) recognized the prevailing risks for women and girls and the need to implement the MISP post-earthquake. Explicit mention of the MISP in needs assessments and policy statements reflected unprecedented awareness and acknowledgement among humanitarian actors regarding the MISP as an international standard of care, which has been integrated into inter-agency guidance on emergency response. Such momentum was further reflected in funding appeals; among the 51 health projects in the revised Flash Appeal, eight addressed MISP implementation and nine addressed broader RH.[1] This is a historic level of commitment to RH in acute emergencies as monitored by the Women's Refugee Commission. Adequate funding for MISP activities and comprehensive RH programs must be provided, to enable sustained and equitable MISP implementation as the situation evolves into a more protracted crisis, especially for the most vulnerable. The activities undertaken by humanitarian and development actors through transition and recovery will reflect how well agencies have committed themselves to the 2009 Granada Consensus on Sexual and Reproductive Health in Protracted Crises and Recovery,[2] a framework of action for RH in crises.

Components of the MISP

> Coordination of the MISP

> Prevent and manage the consequences of sexual violence

> Reduce the transmission of HIV

> Prevent excess maternal and newborn morbidity and mortality

> Plan for comprehensive reproductive health services

> Ensure contraceptives, antiretrovirals and care for STIs are available

Note: All findings and recommendations are dated for the time of the assessment in May 2010.

Key Findings

- **Overall, the assessment team found an unprecedented level of awareness among international**

organizations about the need for priority RH services and stronger efforts to address them, more so than in any previous emergency setting assessed by the Women's Refugee Commission.

- Led by the UN Population Fund (UNFPA) and the Ministère de la Santé Publique et de la Population (Ministry of Public Health and Population) (MSPP) of Haiti, **an RH working group was initiated under the Health Cluster in Port-au-Prince within two weeks of the earthquake.** RH coordination at the subnational level was not established four months post-earthquake. Inter-agency RH kits were available in the early weeks of the crisis, although there was a supply gap spanning weeks at the time of the assessment.

- **Gender-based violence (GBV) was a serious concern prior to the earthquake, and remains a concern following the earthquake: the magnitude of sexual violence, including sexual exploitation and abuse (SEA) at the community level, is a grave public health concern.** Coordination mechanisms to prevent and respond to sexual violence existed, but effective implementation was weak at the community level. The assessment team witnessed many risk factors, including intimidation by rogue male community members, insufficient lighting, communal latrines and bathing facilities with no privacy, lack of a dedicated camp management agency in many camps, insecurity within the camps, and an overall lack of basic necessities, including food, water and livelihoods

- **Clinical care for survivors of sexual assault was offered in a limited number of facilities.** All assessed agencies were aware of the need to refer cases of sexual assault for care. In select facilities in Port-au-Prince and Léogâne, referral cards for GBV services had been developed, although some practitioners were unsure as to whether or not the referral information on the cards was up to date. Health workers reported challenges to ensuring privacy, and the need for psychosocial support for survivors. Communication to the community about the availability and benefit of seeking care was also inadequate.

- **Haiti had strong pre-existing HIV programs, and efforts to continue prevention and treatment post-earthquake were well established.** Health care providers' compliance with standard precautions was generally adequate. Condom distribution was initially strong, although continued supply of condoms was problematic. Disposal of medical waste posed challenges, particularly for smaller facilities that did not have incinerators or access to other disposal methods. Adherence for safe and rational blood transfusion was reported.

- **Emergency obstetric (EmOC) and newborn care was available to varying extents although quality of care and availability of care free of charge, 24 hours per day, seven days per week was not consistent.** Referral pathways appeared problematic for communities without access to communications networks or affordable transport options. Women also reported having very limited access to clean delivery kits. Access to health services for newborn illnesses and complications was a major concern in all three locations.

- **Planning for comprehensive RH care was evident and efforts to facilitate equitable coverage of the MISP were also underway.** The collection of data in order to support these efforts remained a challenge for some agencies. Organizations operating mobile medical care were planning for a transition to increased fixed health facilities, while others were just establishing mobile facilities. Staff needs for training had been identified, particularly for clinical management of rape survivors, sexually transmitted infections (STIs), manual vacuum aspiration and the delivery of comprehensive RH care.

- **The MSPP and many international nongovernmental organizations (NGOs) recognized family planning as a need and supported the provision of contraceptives.** Some agencies offering contraceptives reported stock-outs, particularly for injectables and pills.

- **STIs have been acknowledged as an important component of treatment.** Given existing emphasis on HIV/AIDS prevention and treatment through PEPFAR (U.S. President's Emergency Plan for AIDS Relief), efforts to resume access to antiretrovirals (ARVs) have been strong in Port-au-Prince.

Key Recommendations

- **Funding to UNFPA and the MSPP should be prioritized to ensure consistent staffing for RH coordination within the Health Cluster at the national and sub-national levels.** Funding must also be made available to UNFPA and the MSPP to ensure adequate MISP supplies to scale up equitable coverage of the priority activities of the MISP and build toward comprehensive RH in all affected communities, given the ongoing nature of the emergency.
- **Agencies responsible for security, the Haitian government and humanitarian actors must increase coverage of camp coordination and management, including camp coordination in spontaneous settlements; involve the leadership of women and girls and communities in leadership roles in the prevention of sexual violence; and further address SEA through functioning reporting mechanisms and investigating abuse.**
- **The Health Cluster should scale up efforts to determine and disseminate information to providers and beneficiaries on the current capacity of health facilities to provide good quality, free basic and comprehensive EmOC and newborn care.** The MSPP and NGOs should be further funded to enhance basic and comprehensive EmOC and newborn care services in remote locations of the Southeast Department and Léogâne.

Introduction

The January 12, 2010 earthquake measuring 7.0 on the Richter scale caused massive loss of life and injuries in Haiti. The earthquake struck Ouest Province, an epicenter 17 km south-west of Haiti's capital, Port-au-Prince, which suffered extensive damage. The communes of Carrefour and Jacmel, in addition to other areas to the west and south of the capital were also affected, with the town of Léogâne reportedly 80 percent destroyed. Haitian government estimates placed the death toll at approximately 217,300, and more than 300,600 wounded. Over 97,000 houses were destroyed, and more than 188,000 damaged. According to the government of Haiti, 3 million people were affected, of whom 1.9 million were estimated to have lost their homes.[3]

At the time of the assessment, four months after the earthquake, an estimated 2 million individuals remained displaced in settlement sites in earthquake-affected areas.[4] The Government of Haiti and humanitarian organizations had scaled up their response and developed contingency plans, particularly for food, water, health and emergency shelter with the advent of the rainy and hurricane season.[5]

The RH needs in Haiti were extensively highlighted from the initial days of the crisis: the Reproductive Health Response in Crises (RHRC) Consortium issued a statement on women and girls within a week of the earthquake.[6] Policy documents from the World Health Organization (WHO) and the IASC recognized the prevailing risks for women and girls and the need to implement the MISP in the acute emergency.[7] Explicit mention of the MISP in needs assessments and policy statements reflected unprecedented awareness and acknowledgement among humanitarian actors regarding the MISP as an international standard of care, and integrated into inter-agency guidance on emergency response.[8]

The February 18 revised Flash Appeal[9] included a historic level of commitment to RH: among the 51 health projects in the revised Appeal, eight addressed MISP implementation and nine addressed broader RH, covering one-third of all health appeals.[10] Under Protection, 14 of 51 appeals (27 percent) addressed gender-based violence (GBV) prevention and/or response, with many focusing on psychosocial and mental health issues. As of mid-May, 63 percent of the Health appeal and 64 percent of the Protection appeal had been funded, with the average for RH under Health, and prevention and response to GBV under Protection funded at 45 percent and 47 percent, respectively.[11]

Of the 1,341 camps and spontaneous settlement sites in post-earthquake Haiti, only 206 were reported to have camp management. Hence, only 15.5 percent of sites or 37 percent of the affected population had a dedicated agency for camp coordination.[12] Food, water, shelter and livelihoods remained predominant concerns for displaced populations, and the environment remained ripe for risks to physical security.

Objectives

The purpose of the assessment was to examine the degree of implementation of the Minimum Initial Service Package (MISP) for reproductive health (RH) in response to the January 12 earthquake in three areas that were severely impacted by the earthquake. The specific objectives of the assessment were:

- to identify and document available RH services, gaps and good practices per the five components of the MISP (see box, p. 1);
- to identify key factors that support and hinder MISP implementation;
- to gather community opinions and perceptions on experiences, RH-related challenges and reported knowledge about and access to services.

The MISP is a coordinated set of priority activities designed to prevent and manage the consequences of sexual violence; reduce HIV transmission; prevent excess maternal and newborn morbidity and mortality; ensure contraceptives, antiretrovirals and care for STIs are available; and plan for the provision of comprehensive RH services. The MISP was first articulated in the *Reproductive Health in Refugee Situations: An Interagency Field Manual* released in 1996 for field testing (finalized in 1999). The MISP has since become an international standard of care as articulated in the Sphere *Humanitarian Charter and Minimum Standards in Disaster Response* and the IASC *Health Cluster Guide*.

This assessment is the fifth of a series of MISP assessments the Women's Refugee Commission has conducted; previous assessments were in Pakistan (2002-2003), Chad (2004), Indonesia (2005) and Kenya (2008).

Methods

The assessment methodology consisted of in-depth interviews, facilities assessments, and focus group discussions with displaced populations. Structured interviews were conducted with 34 staff from 21 United Nations (UN) agencies, international and local NGOs and the Ministère de la Santé Publique et de la Population (Ministry of Public Health and Population) (MSPP) of Haiti. Ten facilities of nine agencies were assessed and 14 focus group discussions convened with 329 displaced women, men and adolescent girls and boys. For more detail on the methodology and limitations, see Annex I (page 27).

Reproductive Health in Haiti: Background

Key national RH indicators prior to the earthquake reflect a high maternal mortality ratio of 630 per 100,000

and infant mortality rate of 57 per 1,000 live births.[13] Skilled attendance at birth was measured at 26 percent.[14] The contraceptive prevalence for modern methods was 25 percent.[15] HIV/AIDS prevalence was 2.2 percent, with an estimated 120,000 persons living with HIV/AIDS, more than half of whom were women.[16] To review a breakdown of pre-earthquake RH indicators by region and a list of relevant RH policies, see Annex II (page 28).

MISP awareness and understanding

"This is the first time I have come on a mission, and I have been on many, where everyone is talking about RH. They may not be aware of the MISP and what it means, but they are a lot more aware of reproductive health needs than they were five years ago."

International NGO worker, Port-au-Prince

Situation for 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.

While adolescents were recognized as a large sub-group with immense unmet need,[17] the assessment revealed that few agencies were offering adolescent-friendly services or adolescent RH programs.[18] The daily lives of adolescents were characterized by want of basic necessities. A noticeable number of the focus group discussion (FGD) participants admitted being out of school due to their inability to afford shoes, uniforms and school-related fees. Adolescent boys especially asserted their frustration with want of recreational activities, in particular sports such as basketball and football (soccer). Many wanted jobs. Drug and alcohol abuse was recognized as a problem that remained unaddressed.[19]

Both adolescents and adults in communities reported sexual activity among adolescents to be on the rise,[20] enhancing risks of STIs and unwanted pregnancies. Several community members, including girls themselves, voiced concern over the prevalence of infections, exacerbated by the lack of clean water.[21] Several adolescent boys showed condoms in their possession to FGD facilitators,[22] indicating the delivery mechanism is in place in some camps; distribution was in the form of mobile outreach at three male condoms per month. Boys complained about the low number of condoms distributed; condoms were not available in locations such as schools and once supplies were exhausted, they became another commodity that needed to be purchased from the market.[23]

For adolescent girls, reports of commercial sexual exploitation were gravely worrisome. Several boys admitted to buying sex from girls for small sums of money.[24] Girls requested jobs as a way to prevent having to exchange sex for commodities.[25] The general feeling of insecurity was felt by both genders and younger adolescent boys noted they were scared of people who walked the camp at night, as they resembled ghosts.[26]

While interventions for adolescent RH were limited at the time of the assessment, one agency was employing the Save the Children/UNFPA's *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings*, which complements the adolescent chapter of the 2010 *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*.[27] Agencies were in further discussions to cater to adolescent needs in the form of the Adolescent Girls Project spearheaded by the Population Council.[28]

"PAHO (Pan American Health Organization) is organized per its mandate and uses different methodologies and tools following Emergency Preparedness in Disasters and I was not familiar with humanitarian standards, for example, Health Cluster Guide, Sphere Standards and the MISP, until recently."

Regional agency representative.

RH and MISP awareness was evident to the assessment team and many people commented that there was much more awareness of RH in the Haiti response than in the past. A majority of all interviewees—25 out of 38 people (66 percent)—had heard of the MISP. Though with more in-depth probing, 50 percent of those who had heard of the MISP were not aware of the priority objectives and activities of the MISP.

Recommendations

- 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.
- All agencies should strive to mobilize adolescents to participate in the promotion of their health and well-being.

Coordination of the MISP

PRIORITY ACTIVITIES:

- *Ensuring the health sector/cluster identifies an organization to lead implementation of the MISP. The lead RH organization:*
  - *nominates an RH officer to provide technical and operational support to all agencies providing health services*
  - *hosts regular stakeholder meetings to facilitate implementation of the MISP*
  - *shares information about the availability of RH resources and supplies*

Ensuring the health sector/cluster identifies an organization to lead implementation of the MISP and nominates an RH officer

The health cluster was established in Port-au-Prince at the UN Logistics Base (Logbase) within five days of the earthquake with some 400 national and international NGOs registered as partners.[29] UNFPA was identified as the organization leading RH at the health cluster meeting in Port-au-Prince within two weeks following the earthquake. Health sub-cluster coordination meetings were established and hosted in the MSPP office in Léogâne, and chaired by the Department Sanitaire du Sud Est in Jacmel.[30]

Regular stakeholder meetings to facilitate implementation of the MISP

"RH meetings are useful for information sharing. The UNFPA representative tried to explain MISP and adapted it for the Haiti context."

International NGO worker, Port-au-Prince.

The RH working group in Port-au-Prince was originally led by UNFPA and was subsequently co-led with the MSPP Department of Family Health. According to UNFPA, it was a challenge to bring people together at the beginning, although within several weeks, representatives of a broad array of organizations, including the MSPP, international humanitarian and development NGOs and several UN agencies participated in the weekly meetings. One interviewee reported that there was small resistance from some agencies in Port-au-Prince that the MISP would be in competition with traditional RH programming and that it felt it might be like starting over again without recognizing previous work on RH.[31]

A sub-national RH working group had not been officially established in Léogâne. WHO had hosted one RH-specific meeting in Léogâne several weeks before the assessment mission. PAHO/WHO reported that in Léogâne, "access to health services or health centers is limited and even impossible for populations living in mountainous regions." [32] Interviewees reflected that there were a variety of NGOs working in Léogâne with a wide range in the quality of RH services. Some organizations were not providing RH services in mobile clinics or provided very limited services, such as the distribution of condoms, while others were providing more comprehensive services. Health cluster mapping had been undertaken in Léogâne; however, RH-specific mapping had not yet been done.[33]

In Jacmel, the health sub-cluster covered 10 communes, or geographic divisions.[34] No RH working group was established and RH issues were reportedly addressed at the health cluster meeting, which took place twice a week. One interviewee reported that coordination was needed to bring services to smaller camps still lacking services,[35] while another interviewee noted that access to services outside Jacmel town was limited.[36]

In Port-au-Prince, UNFPA led orientations to the MISP, disseminated supplies to NGOs and collected minimum data (condoms distributed) and linked with the Health and Protection Clusters.[37] In general, RH working group meetings in Port-au-Prince were viewed by many, including development organizations working in Haiti but not experienced in humanitarian crisis, to be extremely valuable for accessing information and RH supplies, and providing an opportunity to meet MSPP and UNFPA representatives. However, others felt there were too many meetings, the meetings were not focused on actions and results,[38] the UN Logbase was far from some NGO offices and the meetings lasted up to two hours. No interviewees recollected that a terms of reference was established for the RH working group or that meeting agendas were set. Several people mentioned that minutes from the meeting were taken in the beginning, but were not saved nor was the effort continued.[39] A problem was also reported that the Health Cluster did not disseminate or post information from the RH working group to the One Response website,[40] an inter-agency website designed to enhance humanitarian coordination within the cluster approach. UNFPA further reported that it was difficult to obtain information about geographic RH coverage and service gaps because few agencies shared this information.[41]

Reflecting the value of RH coordination, albeit the need for improvements, the majority of people who had heard of the MISP and were aware of the RH working group in Port-au-Prince had attended the RH working group meeting at least once, with many attending regularly. However, local NGOs often had difficulty participating in coordination meetings as they were hosted on the UN Logbase, which had restrictive access, resulting in a lack of recognition of their role in the response and a missed opportunity for international organizations to identify and support local capacity in the RH response. Further, in recognition of the importance of building Haitian capacity, a PAHO representative mentioned that there was a lack of sufficient effort by international NGOs to recover and use national protocols. However, many responding international NGOs and UN agencies struggled to obtain copies of national protocols. For example, one UN agency reported having to take a photograph of a national STI protocol in order to obtain a copy for its use.[42] On a positive note, the PAHO representative reported that they are starting to see increased participation of local NGOs in the Health Cluster.[43]

"Turnover in the reproductive health working group meetings is difficult, so more needs to be done to keep people apprised of what the key objectives are for the MISP and what the action plan is."

International NGO worker, Port-au-Prince.

UNFPA reported that both attendance in the RH working group meeting in Port-au-Prince and meeting minutes lagged after a while.[44] In addition, rapid RH coordinator turnover, with up to five RH coordinators in the four months between the earthquake and the assessment mission, appeared to have resulted in a notable

breakdown of the critical link to the Health Cluster.

Sharing information about the availability of RH resources and supplies

The majority of those interviewed reported that free Inter-agency RH kits–kits designed to assist MISP implementation–were available within days after the earthquake. This is the result of UNFPA in-country stockpiles and rapid dissemination, combined with early ordering and procurement undertaken by the UNFPA RH coordinator for Haiti. Agencies reported ordering, receiving and using UNFPA-donated kits, including condoms, clean delivery kits, contraceptives, post-rape kits, STI kits, surgical kits and post-abortion care (PAC) kits.

"UNFPA has done a wonderful job in this regard."

Leading Haitian Obstetrician/ Gynecologist, Port-au-Prince.

UNFPA reports that the first request for the Inter-agency RH kits came on the night of the earthquake and the order they placed was small but comprehensive, including all kits except female condoms and inter-uterine devices (IUDs). The first order arrived within a week but it was not of sufficient quantity to meet demand.[45] Subsequently, a large order was placed with shipments through the Dominican Republic, which took 7-10 days to arrive. In total, three large orders were placed and supplies were distributed to nearly 50 agencies to cover 1.5 million people.[46] In addition, a form for ordering kits was created and posted on the One Response website. The lack of logistics assistance in the first weeks following the earthquake created a burden on the RH coordinator because some agencies were unfamiliar with necessary quantities or simply ordered too many kits. This required the RH coordinator to meet and provide guidance to each representative requesting supplies to secure more appropriate orders.[47]

However, at the time of the assessment, many interviewees reported RH kit supply stock-outs of two months, specifically mentioning pregnancy tests and clean delivery kit shortages. Agencies such as Médecins Sans Frontières (MSF) that do not depend on supplies from UNFPA were not affected by UNFPA's shortages. Partners in Health (PIH) reported that they requested the RH post-rape kits from UNFPA but did not receive them.[48]

"RH supply shortages hit about one month after the earthquake."

International NGO worker, Jacmel.

One key issue related to the RH kit supply shortage was the result of a gap in quantity of supplies ordered, which was based on a population of 1 million versus the total affected population of 3 million. Another issue may have been the lack of recognition of Haiti's ongoing crisis with inequitable MISP service coverage, as some agencies were additionally initiating mobile clinics to expand MISP services or were asked by UNFPA to begin making their own clean delivery kits to avoid supply wastage and to move to a cost-effective medical supplies logistics system. One interviewee from an international NGO expanding mobile clinic coverage said they were too overwhelmed with the immediate response to engage a local group to make clean delivery kits.

Recommendations

- Funding to UNFPA and the MSPP should be prioritized to ensure consistent staffing for full-time RH position(s) dedicated to the humanitarian response at national and sub-national levels, with additional administrative and logistics positions for at least one year to address RH coordination within the Health Cluster, while also ensuring national participation.
- International RH coordinators should, at the onset of their work, hire a local counterpart to shadow the international RH coordinator position(s) to ensure a smooth transition during staff turnover and ultimately assume responsibility with the MSPP for RH coordination.

- The RH sub-working group should work closely with the Health Cluster, the Camp Coordination and Camp Management (CCCM) Cluster and the Protection Cluster, particularly the GBV sub-cluster, through regular briefings at the cluster meetings on key RH issues of concern, sharing of minutes and participation in assessments and strategic planning sessions.
- MSPP and UNFPA should strengthen RH coordination meetings by hosting them within the MSPP Office that is more accessible to local organizations and by establishing action-oriented agendas and disseminating meeting notes to all participants and ensuring they are posted on the One Response website.
- Funding must be made available to ensure adequate MISP supplies to scale up equitable coverage of the priority activities of the MISP and build toward comprehensive RH in all affected communities for at least one year.

Prevent and Manage the Consequences of Sexual Violence

PRIORITY ACTIVITIES:

- *Ensuring systems are in place to protect displaced populations, particularly women and girls, from sexual violence*
- *Ensuring medical services, including psycho-social support, are available for survivors of sexual violence*
- *Ensuring community is aware of available clinical services*

As reported in various media outlets and situation reports from the initial days of the earthquake,[49] sexual violence, commercial sexual exploitation and SEA were a public health concern. According to the National Human Rights Defense Network, the Haitian police made approximately 2,250 arrests between the months of February and April 2010. Among them, at least 534 arrests, or 23.7 percent, were related to sexual violence.[50] A 2006 survey published in *The Lancet* further noted that between February 2004 and December 2005, 35,000 women were estimated to have experienced sexual assault in Port-au-Prince, more than half of whom were younger than 18.[51]

Indeed, while some communities where focus group discussions were convened did not report rape or exploitative sex taking place, providers in the same area mentioned actual rape cases.[52] In other communities, women and girls said that sexual assault and the risk of sexual assault were significant concerns, especially in relation to the lack of protective measures, basic necessities and jobs in the camps and other informal settlements.

"Everything that you could possibly think of got worse, especially for us women."

Female focus group discussion participant, Mitton, Léogâne.

Women and girls in several focus group discussions noted having to trade sex with people in positions of authority, such as humanitarian actors (local and international agency staff) and peacekeepers, for protection and basic necessities.

Ensuring systems are in place to protect displaced populations, particularly women and girls, from sexual violence

Haitian authorities have established a Ministry of Women's Affairs and Women's Rights and adopted the 2006-2011 *National Plan of Action to Combat Violence Against Women*[53] in 2005. Despite this, little has been achieved in implementing these commitments.

In addition, tragedy arose with members of the Ministry of Women's Affairs and the gender equality movement perishing in the earthquake.[54] While deliberations have taken place at the policy level, the Haitian Parliament is yet to pass the 2005 Presidential decree on sexual violence and to establish a legal framework protecting women and girls from all forms of violence.

At the response level, the Gender-based Violence (GBV) Sub-Cluster was established under the Protection Cluster soon after the earthquake, with efforts undertaken to facilitate other clusters to address gender concerns as a cross-cutting issue.[55] The systems to support the protection of displaced populations at the national level, however, had not been sufficiently established at the camp and community levels to effectively enforce prevention measures, especially in areas further removed from Port-au-Prince. Interviewees and community members noted that very few initiatives effectively engaged women in planning processes. Site visits and focus group discussions revealed the lack of basic protection measures in many of the camps and a failure to meet minimum GBV standards,[56] including insufficient lighting; latrines and shower stalls without locks and not separated by sex; overcrowding; and tents that unzipped easily from the outside.

The presence of rogue men and boys in some camps in Port-au-Prince and the absence of a dedicated camp management agency in others further contributed to protection risks. Some camps had arranged for or assembled their own security committees, but this effort was ad hoc and not uniformly effective.[57] The lack of basic necessities, including food, water and shelter, especially in light of the heavy rains, in addition to limited livelihood opportunities, compounded risks for women and girls. Focus groups conducted among women in all three locations cited the need for employment and jobs as a factor that would help prevent women and girls from having to engage in survival sex.

"Some [girls] sleep with you for money. It happens a lot. Of course they are hungry."

Adolescent male focus group discussion participant, Santo, Léogâne.

As part of efforts to prevent SEA, 11 of the 18 agencies interviewed had instituted a Code of Conduct for staff; however, the extent of coverage varied. Some applied the Code to both international and national staff, while others only included expatriate staff. Agencies such as CARE had a team dedicated to responding to claims of SEA[58] while the International Rescue Committee (IRC) instituted mandatory reporting policies.[59] While the assessment team's interviews revealed a lack of clarity regarding the entity coordinating SEA, reports noted that the UN Office for the Coordination of Humanitarian Affairs (OCHA) was organizing a Prevention of SEA (PSEA) Core group and an in-country focal point network, comprising at least one focal point from each agency.[60] The Gender Capacity Standby Project (GenCap) is further tasked with addressing this issue.[61]

Ensuring medical services, including psycho-social support, are available for survivors of sexual violence

While agencies reported that initially care for survivors of sexual assault was not available and establishment of such services was slow,[62] all assessed agencies were aware of the need to refer cases for post-rape care. Several agencies in Port-au-Prince and Léogâne were equipped with referral cards with a list of heath facilities.[63] It was not clear if the information listed in the cards was current or whether services had been thoroughly vetted for quality and 24-hour availability. Mapping and monitoring efforts of service availability appeared to be most problematic in Jacmel. In Port-au-Prince, IRC had mapped existing hospitals and assessed quality of care.[64]

Among many of the major programs and facilities that offered clinical care, supplies appeared to be available and staff had been trained on the national protocol[65]

by the time of the assessment. Responding agencies reported discrepancies between the national and WHO protocols and practices. First, the national STI treatment protocol differed from the drugs contained in the Inter-agency RH Kits, resulting in reports of facilities initially sending women to purchase their own antibiotics.[66] Second, access to post-exposure prophylactics (PEP) also differed depending on location; as some agencies needed to refer clients.[67] Vaccines for Hepatitis B were not available in most facilities.

Challenges with ensuring privacy in mobile facilities were reported[68] and recent reports indicated the lack of adequate psychosocial support for survivors.[69] The need to better respond to child survivors was also raised. Increases in unsafe abortion were noted by several agencies.[70] Among the sites visited by the assessment team, the facility offering the most comprehensive clinical care for sexual assault survivors was, by far, MSF Switzerland in Léogâne. The assessment team was not able to determine whether existing facilities offering clinical care provided adequate geographic coverage.

Ensuring the community is aware of available clinical services

"Couldn't we have a clinic so that after we are raped, they can just wash us out?"

International NGO staff, Port-au-Prince.

The overwhelming majority of focus group discussion participants in all three locations were neither aware of the health benefits to seeking clinical care after experiencing sexual assault nor aware of where they could receive available services. These findings were corroborated by several international NGOs, which lamented that very few survivors were seeking care, citing the lack of privacy, fear and other reasons.[71] The GBV Sub-Cluster undertook efforts to develop information, education, communication (IEC) materials to inform communities about getting help within 72 hours of sexual assault. Past efforts also included conveying information via the radio.[72] Continued emphasis on informing communities on the benefits of seeking care was needed to increase demand for available services.

"Where would you report a problem like this? In your heart."

Female adolescent focus group discussion participant, Mitton, Léogâne.

Recommendations

- The CCCM Cluster, the government and all humanitarian actors must expand security by increasing coverage of camp coordination and management, including to spontaneous settlements; involve the leadership of women and girls and communities in the prevention of sexual violence; and further address SEA through functioning reporting mechanisms and investigating abuse.
- Health agencies should strengthen efforts to identify and support facilities that provide clinical care for rape survivors by further assessing the capacity of health facilities to provide good quality (trained staff, sufficient supplies) free clinical care while simultaneously informing communities of the importance and specific benefits of seeking health care and how to access health services. Referral systems should be put in place that take into consideration transport for those who are unable to pay. The IEC effort should be synchronized with mapping/monitoring of health facilities to ensure that communities are informed of changes to service availability.
- The GBV response should better involve, support and build the capacity of Haitian women's organizations in efforts to prevent and respond to sexual violence at the community level.
- Humanitarian and development actors should consider livelihood opportunities for women and girls as mitigating factors for SEA and transactional sex.

Reduce HIV Transmission

PRIORITY ACTIVITIES:

- *Ensuring safe and rational blood transfusion practice*
- *Facilitating and enforcing respect for standard precautions*
- *Making free condoms available*

Haiti's HIV/AIDS prevention, treatment, care and support programs prior to the earthquake, supported by the US President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund),[73] likely contributed to mitigating the risks of HIV transmission in Haiti induced by the immediate impact of the earthquake and the ongoing post-earthquake population displacement and disruption of national systems and civil society. UNAIDS reports that 120,000 people lived with HIV and the adult HIV prevalence was 2.2 percent prior to the earthquake.

"Yes, the whole [Sud Est] Department accepts distribution of condoms and educating the people and these services started way before the earthquake."

Government representative, Jacmel.

Most FGD participants were aware of HIV and frightened about becoming infected, with some viewing HIV/AIDS as a "death sentence." FGD participants were generally knowledgeable about the major causes of HIV transmission, and frequently cited abstinence, being faithful and condoms (ABC) as the means to prevent it.

Ensuring safe and rational blood transfusion practice

The MSPP National Blood Safety Program was seriously impacted by the destruction of the building that housed the program and the National Center for Transfusions. Safe blood for transfusion was not available for the first eight days after the earthquake, leading PAHO/WHO to coordinate and distribute international blood donations until the system was fully re-established.[74] The overwhelming majority of interviewees recognized the existence of MSPP policies on safe blood transfusion. The assessment team was informed by health providers that where blood transfusions should have been available, blood was available and safe, although one NGO representative stated experiencing a shortage of safe blood.[75] UNFPA reported that Haitian blood banks had started functioning since the earthquake.[76]

Facilitating and enforcing respect for standard precautions

Standard precautions–infection control measures to reduce the risk of transmission of blood-borne pathogens through exposure of blood or body fluids among patients and health care workers–were reportedly practiced for the most part by NGO staff from the start of operations. UNFPA reported disseminating supplies for the practice of standard precautions. There was only one report of supply shortages that included masks, glasses and aprons in the operating theater at La Paix Hospital in Port-au-Prince.[77] Many interviewees acknowledged the existence of MSPP policies addressing standard precautions and occupational exposure[78] for health care workers. Health care representatives with whom the assessment team met mentioned that Haitian health providers were generally good at practicing standard precautions and hospitals had sterilization capacity, but further training should be supported.[79]

There was no evidence of visual job aids for standard protocols or systems for monitoring standard precautions through simple checklists in the health facilities visited by the assessment team. In addition, while most respondents indicated that occupational exposure protocols were in place, with one agency specifically citing their PEP and wound care protocol for international and national staff,[80] the assessment

team did not obtain details about agencies' specific steps to address occupational exposure.

WHO/PAHO have distributed materials such as plastic bags and sharps containers to health facilities and NGOs, and they are working with the Haitian Department of Solid Waste Management to collect health care waste from hospitals to transport to pits.[81] Some NGOs reported bringing their medical waste to the public hospital, while others reported using offsite incinerators. Smaller NGOs faced more difficulties addressing waste disposal.[82]

Making free condoms available

"The first thing we did was to get condoms everywhere and people took them and were using them. There was a big demand for them; we pushed out millions of condoms. Now condoms are a problem—the effort wasn't sustainable and there were problems with how some of the condoms were distributed."

International UN agency representative, Port-au-Prince.

Many focus group participants informed the assessment team that male condoms were widely distributed free of charge at the start of the emergency in Port-au-Prince, Léogâne and Jacmel. At the time of the assessment people could go to a hospital or possibly get condoms from an international NGO, but they would have to purchase them and they did not have the money to do so. However, one group of male focus group participants in Martissant camp in Port-au-Prince said MSF had condoms available in its clinic and was distributing them in the camp and that there were enough. The executive director of a local feminist organization in Jacmel also reported that they received condoms from UNFPA in the past but was not receiving them anymore.[83] Many FGD participants in Port-au-Prince had not heard of female condoms and said they were not available, although roughly half of the FGD participants in Léogâne appeared to know about them.[84]

"Female condoms aren't available; it surprises me because it would be so useful."

International NGO worker, Port-au-Prince.

Recommendations

- MSPP, the Health Cluster and humanitarian agencies should sustain supplies and integrate systems for monitoring and supervision of standard precautions, including occupational exposure for health care workers, in all health facilities.
- MSPP and UNFPA, with NGOs, should resume coordinated free condom distribution to all camps, spontaneous settlements and affected populations, keeping in mind that with the desperate circumstances in many settings, condoms must be carefully distributed to beneficiaries to prevent use of the commodity for exploitation and abuse.
- MSPP and the Health Cluster should make the female condom widely available in Haiti.

Prevent Excess Maternal and Newborn Morbidity and Mortality

PRIORITY ACTIVITIES:

- *Ensure availability of emergency obstetric care (EmOC) and newborn care services, including:*
  - *At health facilities: skilled birth attendants and supplies for normal births and management of obstetric and newborn complications*
  - *At referral hospitals: skilled medical staff and supplies for management of obstetric and newborn emergencies*
- *Establish a 24/7 referral system to facilitate transport and communication from the community to the health center and between health center*

and hospital

- *Provide clean delivery kits to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible*

Ensure availability of EmOC and newborn care services

"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." [85]

Leading Haitian Obstetric
Gynecologist, Port-au-Prince.

The MSPP has a national policy for free obstetric care in public health facilities.[87] Due to constrictions on time and capacity, the team was unable to assess availability of EmOC as per the standards outlined in the MSPP national policy or the UN process indicators. The team was able to determine that EmOC and newborn care was available to varying extents in the three settings assessed, although the quality and availability of care, free of charge, 24 hours per day, seven days per week were not consistent. Over all, coverage of EmOC appeared to be very low in rural areas outside Jacmel and Léogâne, although definitive numbers on coverage were difficult to attain.[88]

In Port-au-Prince, two facilities assessed offered comprehensive emergency obstretic care (CEmOC). Of the facilities assessed, only one reported that it provided CEmOC care seven days per week, 24 hours per day, free of charge.[89] Fewer than five health care providers interviewed, who represented three different clinics, reported providing basic EmOC (BEmOC)

Basic and Comprehensive EmOC and Newborn Care[86]

> Ensure basic EmOC and newborn care at all health centers. This means that staff are skilled and have the resources to provide:

- parental antibiotics
- parental uterotonic drugs (oxytocin)
- parental anticonvulsant drugs (magnesium sulfate)
- manual removal of retained products of conception using appropriate technology
- manual removal of placenta
- assisted vaginal delivery (vacuum or forceps delivery)
- maternal and newborn resuscitation

> Ensure comprehensive EmOC and newborn care at hospitals. This means that staff are skilled and have the resources to support all of the interventions above, as well as to:

- perform surgery under general anesthesia (Cesarean delivery, laparotomy)
- provide rational and safe blood transfusion

services. Mobile clinics, serving many displaced settlements and camps, were not able to provide BEmOC. One practitioner noted that the facility at which he worked was the only hospital providing CEmOC in Croix de Bouquets, serving an estimated population of 200,000, including surrounding regions.[90]

Coverage outside of Port-au-Prince was significantly reduced. Of the facilities assessed, only one hospital in Léogâne provided CEmOC, covering an estimated population of 190,000,[91] and no assessed clinics provide BEmOC services. The Cuban Hospital, run by the Cuban government, was reported to be providing EmOC services, although the assessment team was not able to verify this finding. In Jacmel, only one hospital was providing CEmOC, covering an estimated population of 500,000.[92] No clinics assessed were providing BEmOC.

Although no health care providers interviewed were able to provide exact numbers of maternal deaths that had occurred since the earthquake, three health care providers representing different facilities reported maternal deaths occurring in their facilities. One reported three maternal deaths in the past 20 weeks.[93] Causes of maternal deaths were attributed to postpartum hemorrhage, eclampsia, sepsis, toxemia and complications resulting from unsafe abortions.[94] Collection of data on maternal deaths appeared to be inconsistent across the facilities assessed. Several health care providers called for increased attention to maternal deaths, identifying it as a concern.

"Maternal mortality is elevated and we need to do advocacy on this issue."

International UN agency representative, Port-au-Prince.

Access to health services for newborn illnesses and complications was raised as a major concern by health care providers in all three sites. One provider reported, "We gave out newborn kits as a part of antenatal care but we could have done much more." No facilities assessed appeared to have comprehensive neonatology services in place. One practitioner in Port-au-Prince reported having to refer neonates with complications to a pediatrics clinic.[96] Two others reported that the hospitals at which they worked had no comprehensive neonatal services and no incubators.[97]

"There is a need for neonatology services; there are none, not even in Port-au-Prince."

International NGO health care provider, Léogâne.

Three health care providers representing three distinct facilities reported increased numbers of women presenting for postabortion care (PAC).[99]

A lack of trained midwives was repeatedly raised as a critical obstacle to providing quality maternal and neonatal health care. Educated professionals were reported to have left Haiti[100] and higher wages paid by international NGOs were cited as contributing factors to the lack of midwives serving in public facilities.[101] According to a representative from the International Midwives Association, traditional birth attendants (TBAs), known as "matrons," were filling the unmet demand.[102] While midwives reportedly "tutor" matrons, matrons were not certified and are not providing skilled care. According to many health care providers, there are more matrons than midwives available.[103]

"Before the earthquake there were 300-400 trained midwives, now there are only 100 available."

International NGO health care provider, Port-au-Prince.

Establish a 24/7 referral system to facilitate transport and communication from the community to the health center and between health center and hospital

Referral pathways appeared problematic for communities without access to communications networks or affordable transport options, particularly in the more remote camps and settlements in Léogâne and Jacmel.

The situation of the pregnant woman (see p. 16) in Jacmel was not unique. In every focus group conducted

This woman will have to walk for 45 minutes to access the nearest road. From there she will have to negotiate transportation to the nearest hospital. During the rainy season, the path to the road will be impassable. If she goes into labor then, she will have to deliver in the camp. There is one elderly TBA in the camp to help her. She did not receive a clean delivery kit.

with adults in Port–au-Prince, Léogâne and Jacmel, participants reported that it was common to deliver in the camps with the assistance of a midwife, TBA or family member if access to a hospital was not possible due to lack of transport or money to cover incidentals, or if the woman went into labor at night. In all settings, the reported cost of hospital care presented a huge barrier for many women. While the delivery of actual services may be free, medicine, needles, food and other associated costs were not always free.[105]

Transportation issues plagued not only the rural settlements in Léogâne and Jacmel, but also the urban areas of Port-au-Prince and Jacmel. Transport to referral hospitals was available 24/7 in only one facility and site assessed. Two clinics reported a lack of ambulances or vans to enable consistent transport to referral facilities.[106] As one health care provider stated, "most people have to find their own transport at night and on weekends."[107]

Clinics, frequently serving as the first point of referral for women in settlements and displacement camps, were often not staffed at night.[108] In many interviews, health care providers cited a lack of referral networks as a huge obstacle.[109] In interviews and facilities assessments in all three sites, discrepancies in answers across agencies regarding referral options (i.e., which health care facilities offered which services, when and where) were striking. To sum up, "referral is ad hoc–there is not much access to services, very little referral and very little follow up."[110]

GOOD PRACTICE: Improving Referral Mechanisms

The international NGO Merlin used a checklist of criteria to assess the referral hospital for capacity to provide EmOC before referring patients.

Provide clean delivery kits to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible.

Women also appeared to have very limited access to clean delivery kits, in spite of agencies reporting distributions in the thousands. Service providers from Save the Children, CARE, UNFPA, Merlin and Partners in Health reported a backlog on orders for clean delivery kits that had spanned more than a month.

"We distributed almost 900 clean delivery kits in the early days. Since March we have not received any clean delivery kits for distribution."

International NGO health care provider, Port-au-Prince.

Recommendations

- The Health Cluster should scale up efforts to determine and disseminate information to providers and

beneficiaries on the current capacity of health facilities to provide good quality, free basic and comprehensive EmOC and newborn care and provide information on the hours the facilities are open. RH practitioners should use this information to establish a birth plan with all pregnant women in their communities.

- The MSPP and NGOs should be funded to enhance basic and comprehensive EmOC and newborn services in remote locations of the Southeast Department and Léogâne.
- Ambulance services with communication systems are needed in all three locations to facilitate referrals, especially at night and during weekends.
- Midwife training programs should be supported. Equal pay structures should be adhered to across all health facilities.
- The distribution of clean birth kits must be renewed, specifically targeting areas where referral pathways are compromised. Local capacity should be identified to assemble clean delivery kits.

Plan for Comprehensive RH Services, Integrated into Primary Health Care (PHC) as the Situation Permits. Support the Health Sector/Cluster Partners to:

- *Coordinate ordering RH equipment and supplies based on estimated and observed consumption*
- *Collect existing background data*
- *Identify suitable sites for future service delivery of comprehensive RH services*
- *Assess staff capacity to provide comprehensive RH services and plan for training/retraining of staff*

"Before the earthquake, we weren't so good at taking care of women. After the earthquake, many were displaced—some even to more rural provinces. They are living in very poor conditions. It was hard to prevent some of the risks affecting this population. In health care facilities, we don't have sections dedicated to women's health. We need to provide more women-friendly services. There are lots of social barriers to women. In some communities, women don't have the right to be sick. We have to replace this way of thinking." [112]

Leading Haitian Obstetrician/
Gynecologist, Port-au-Prince.

Signs of planning for more comprehensive care were evident. At the time of the assessment, UNFPA and the MSPP were planning to develop a more comprehensive strategy for RH.[113] The plan that was ultimately developed (see below) outlined a coordinated effort by UNFPA and the MSPP to implement a more comprehensive RH care package at the national level during the transition from acute crisis to a more protracted crisis. The objectives of the plan include: [114]

- Improving the availability of information concerning the RH of displaced persons by gathering information in 130 temporary camps and 250 health centers located near camps in Port-au-Prince;
- Reviving the National Schools of Nurses and Midwives by reestablishing midwife training programs;
- Working with UNICEF to set up 10 clinics to provide skilled RH services especially geared towards basic newborn emergency care;
- Supporting the Haitian Association of Obstetricians-Gynecologists in establishing a referral service for maternal and neonatal health services;
- Working jointly with Haitian authorities, UNICEF and WHO on reducing maternal mortality by strengthening the quality of RH services in a number

of hospitals and clinics.

Collect existing background data

The collection of data in order to support RH efforts remained a challenge for some agencies. While the Health Cluster's disease surveillance captures the number of women with pregnancy complications and cases of STIs, not all agencies were sending information. This finding was consistent with an evaluation of the Internally Displaced Surveillance System (IDPSS), developed by the Centers for Disease Control and Prevention (CDC), MSPP and PAHO to monitor disease outbreaks and trends affecting populations displaced by the earthquake.[115] This surveillance system also included RH indicators– *the number of pregnancies seen with complications, third trimester pregnancies without prenatal care and the number of patients with interrupted antiretroviral therapy*.[116] However, reporting on this system had not been consistent, nor were findings reportedly shared extensively at the time of the assessment. Overall, data collection and reporting on RH indicators to the RH working group and MSPP reportedly remained low.

That being said, many service providers reported collecting data on the number of deliveries, number of deliveries with complications, number of cesarean sections, number of low birth weight babies and numbers of maternal and newborn deaths within their organization.[117]

Coordinate ordering RH equipment and supplies based on estimated and observed consumption

UNFPA organized a survey for the Inter-agency Working Group (IAWG) on Reproductive Health in Crises on the RH Kits. The purpose of the survey was to evaluate the distribution strategy and the impact of the RH kits on the population, in order to "adapt the content of the kits and improve future distribution."[118]

Identify suitable sites for future service delivery of comprehensive RH services

Organizations operating and supporting mobile facilities since the start of the earthquake had begun planning for a transition to increased fixed health facilities.[119] UNFPA and Save the Children have already identified national sites they will support to make more comprehensive services available in Port-au-Prince, Léogâne and Jacmel.[120] MSF Switzerland was building a two-year transitional hospital in Léogâne[121] to address more comprehensive needs. As an MSF representative explained, "We need fixed sites for RH and family planning… the challenge with mobile clinics is that there is no schedule for services."[122]

While some agencies were focusing on fixed sites through which to deliver comprehensive care, other organizations, such as Merlin, were just establishing mobile clinics to improve primary health coverage in areas still not served.[123] Other efforts to expand coverage included plans to develop a more "home-based approach" by Partners in Health to address unmet RH needs.[124]

Assess staff capacity to provide comprehensive RH services and plan for training/retraining of staff

Priority staff training needs identified by health care providers interviewed include:

- TBAs should be better integrated into health services
- clinical management of rape survivors
- treatment of STIs
- manual vacuum aspiration and the delivery of comprehensive RH care[125]

Recommendations

- The national RH working group should develop and

GOOD PRACTICE: Capacity Building

MSF Switzerland reported on its capacity-building strategy that was underway to train national staff to take over operations currently overseen by international staff. To this end, the MSF Switzerland hospital in Léogâne employed two international midwives, one focusing exclusively on the recruitment and training of national midwives.[126]

provide implementing agencies with a standardized reporting form to gather RH data on a regular basis from each agency, including from the MSPP; analyze the information; share the synthesized report with the Health Cluster; post on One Response; and disseminate to the wider humanitarian community,

- The MSPP and UNFPA should work with the RH working group within the Health Cluster to compile a detailed summary of RH training needs and training plans.
- All agencies should expand community outreach and mobilization to better link communities with services.

Additional Priority Activities in the MISP

- *It is also important to ensure contraceptives are available to meet the demand, syndromic treatment of sexually transmitted infections (STIs) is available to patients presenting with symptoms and antiretrovirals (ARVs) are available to continue treatment for people already on ARVs, including for prevention of mother-to-child transmission (PMTCT). In addition, ensure that culturally appropriate menstrual protection materials (usually packed with other toiletries in "hygiene kits") are distributed to women and girls.*

Ensuring contraceptives are available to meet demand

The need for and availability of contraceptives to the displaced population appeared to be more acknowledged and addressed in the post-earthquake response than in any settings previously assessed on the MISP by the Women's Refugee Commission. This may be attributed to both the long-standing family planning programs of the MSPP and development organizations supporting the continuation of contraceptive distribution in the immediate aftermath of the crisis. This is coupled with increasing recognition among humanitarian responders of women's demands for contraception in crisis settings and the recently revised MISP standards, which include making contraceptives available at the onset of an emergency.[127] However, contraceptive supply shortages were a problem and notable gaps were observed in the awareness, understanding and use of emergency contraception.

"People aren't comfortable with emergency contraception, even though it is legal."

International NGO worker, Port-au-Prince.

Family planning is a major gap in Haiti, with unmet need at 37.5 percent and a contraceptive prevalence of 25 percent.[128] All public facilities visited reported having injectables (Depo Provera), pills (combined oral contraceptives and Progestogen-only contraceptive pills) and condoms, although facilities varied in terms of their capacity to offer implants (Jadelle), intrauterine device (IUDs) and tubal ligation. Facilities that did not offer IUDs or implants reported a lack of trained staff to insert them as reasons.[129] Stock issues were also reported, with some agencies mentioning that UNFPA

was out of contraceptive supplies. One agency noted that it wanted to strengthen its family planning efforts, but securing contraceptive commodities was a challenge and they instead referred clients to MSPP clinics.

Among NGOs in Port-au-Prince, Medécins du Monde (MDM) and Partners in Health (PIH) actively provided contraceptive supplies in the immediate aftermath of the earthquake. Both organizations reported high demand of Depo Provera, with PIH noting that sensitivity to the method declined after the earthquake. Despite the uptake, an MDM representative said midwives and MSPP staff could benefit further from training and capacity building in family planning.[130] A PIH interviewee explained that family planning was a major challenge in Haiti because of high levels of misinformation, even among health workers, about side effects. In addition, there are many unwanted pregnancies and reports of infanticide and maternal suicide.[131]

PIH reported providing family planning at all facilities and an active network of community health workers providing family planning from tent to tent.[133]

GOOD PRACTICE: Providing Contraception at the Start of the Emergency

Medécins du Monde (MDM) used existing funding to address the high demand for contraceptives at the beginning of the emergency response by making free contraceptives available through mobile clinics in 15 camps in Cité Soleil. The agency noted the availability of funds as a key factor in its ability to provide family planning,[132] reflecting the importance of preparedness and contingency planning.

In Léogâne, some organizations provided condoms, pills, injectables and sterilization, while others only made condoms available or referred patients to other sites for all methods.[134] Similarly, in Jacmel, the availability of contraception depended on the organization, and several interviewees reported that combined oral contraceptives, progestin-only contraceptives, injectables and male condoms were available at St. Michel's Hospital, while IUDs and implants were not.[135]

Among communities, demand for and access to contraceptives were hindered by availability; lack of knowledge about methods, particularly emergency contraception (EC); misperceptions on side effects; cultural taboos, especially among adolescents; and perceived costs. Abortion was discussed as a real and frequent occurrence, with communities noting salt water and frozen Coca Cola among other options to induce abortion.[136] Many focus group participants, including adolescents, cited some modern methods of birth control to prevent pregnancy, such as condoms, pills, IUDs and Norplant, and a significant number also cited methods such as withdrawal, herbs and teas. Apart from one woman, no FGD participant indicated an awareness of emergency contraception.

Ensuring syndromic treatment of STIs is available to patients presenting with symptoms

The conditions in Haiti are ripe for the spread of STIs as vulnerability to STIs increases with poverty, food insecurity, lack of access to health services, mobility and lack of protection against violence and/or exploitation.[137] All of these risk factors were apparent in Haiti during the assessment team's visit. Studies have shown the highest risks for some STIs in Haiti are associated with economic factors.[138] FGD participants also commented on increased sexual activity, including sex outside of marriage, meeting survival needs, seeking relief from the dire situation, boredom and wanting to have sex before life ends.

"Yes, there are many men and women who have sex

outside of a marriage and of course some people think it is wrong. It happens everywhere."

Female focus group discussion participant, Mitton, Leogane.

The MSPP was often reported to have an established policy on the syndromic treatment of STIs, although slightly different from the WHO protocol. The MSPP protocol was reportedly unavailable to some international NGOs that were following MSF or WHO protocols.[139]

Regarding STI services, all PEPFAR centers in Haiti were reported to screen for syphilis.[140] With some exceptions, most international NGOs with which the assessment team met were providing syndromic treatment in health facilities and at mobile clinics. In health facilities visited in Léogâne, syndromic treatment was available for genital ulcer syndrome (GUS) and urinary discharge syndrome (UDS) in one clinic, but not for vaginitis and cervicitis.[141] There was a mixed response regarding the availability of STI services at St. Michel's hospital in Jacmel.[142] Save the Children reported providing syndromic treatment for GUS, UDS and vaginal discharge syndrome (VDS) with their health services in Jacmel.[143] One CARE representative reported that the Haiti health system was familiar with syndromic approach and most clinicians had been trained but refresher training was needed.[144] Supplies were reportedly available through Inter-agency RH Kit 5.[145]

Generally, FGD participants could name a few STIs, such as HIV, syphilis, chlamydia, herpes and genital warts. Men could usually identify symptoms and the importance of condom use in preventing them. Many FGD participants knew to go to the hospital for testing if they had symptoms, but money to purchase medication in the market or at a pharmacy was a problem. Some mentioned that a person could get treatment at GHESKIO, the Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections, while others mentioned seeking care from midwives and using herbal remedies such as tea with leaves and basil. A

GOOD PRACTICE: Treatment Protocols Made Clear

At a Merlin mobile clinic in Port-au-Prince, STI protocols were hung on a clothes line and Save the Children was reported to have posters on treatment protocols in all of their mobile clinics.

representative of a development organization said treatment was a challenge because men have multiple partners and women are afraid to ask men to seek treatment.[146]

"Men don't like to go to the hospital and get treatment so it is hard to keep track of."

International NGO worker, Port-au-Prince.

Ensuring antiretrovirals (ARVs) are available to continue treatment for people already on ARVs, including for prevention of mother-to-child transmission (PMTCT).

A concerted and largely successful effort to ensure ARVs were available to continuing users in the displaced population appeared well underway from the earliest days and weeks and continuing at the time of the assessment team's visit.[147] Some stock shortages for PMTCT were reported due to logistics post-earthquake. There also appeared to be a major gap in some emergency response providers and in FGD participant awareness of the availability of free HIV treatment, care and support programs.

UNAIDS reports that approximately 70,000 of the 120,000 (nearly 60 percent) people living with HIV were from areas directly impacted by the earthquake. At the time of the earthquake, approximately 19,000 people were estimated to be on ARVs. A UNAIDS

country team situation analysis within the first month showed that the GHESKIO Center, established in 1982 in Port-au-Prince and a renowned clinical service, research and training center for HIV/AIDS and related services, had accounted for 80 percent of the 6,000 people receiving free treatment from its Center. GHESKIO further reported sufficient stocks of ARVs. In the days following the earthquake, the UN Country Team on AIDS also visited Hôpital de la Paix in Port-au-Prince, which was reported to suffer stock losses with services shut down for 12 days. The initial situational analysis by the UNAIDS country team identified several short-term priorities, including limiting treatment interruption, providing nutritional support for people on treatment and ensuring PMTCT services were re-established.[148]

As noted in previous sections, AIDS care and treatment had been a priority for Haiti before the earthquake. As such, public hospitals and 90 percent of health centers reportedly had adequate partnerships through the Global Fund with the MSPP for ARVs. One HIV/AIDS expert noted that each of the 10 departments in Haiti has a university hospital with free HIV services, including ARVs.[149]

In Léogâne, a WHO representative reported that ARVs were available through MSF Switzerland and at the sanatorium for continuing users and PMTCT, but that supplies were insufficient.[150] MSF Switzerland also reported that adults were referred to the sanatorium in Léogâne for both tuberculosis and HIV/AIDS and that pediatric clients were referred to the GHESKIO Center in Port-au-Prince for ARVs.[151] One international NGO providing primary health services in Léogâne reported that ARVs were not available.[152] In Jacmel, the subnational Health Cluster coordinator, MSPP director and representatives of MSF Spain and Save the Children reported that ARVs were available at St. Michel's Hospital for continuing users, including for PMTCT, and clients were referred to the hospital.[153]

While agencies reported ARV availability, albeit limited, some FGD participants did not seem aware that there were HIV treatment and care options, suggesting the possibility of a critical gap in knowledge. However, one interviewee said this might be due to the fact that some people were afraid others would see them if they went to a public facility and that private facilities would charge money for ARVs.[154]

"Some people are still in the 80's and don't know about services while funds have also diminished in HIV for information, education and communication. For example, a person doesn't see advertising on HIV such as billboards about where to get tested."

International NGO worker, Port-au-Prince

Ensuring culturally appropriate menstrual protection materials

Most FGD participants reported that women and girls were using pads or tampons for menstruation which could be purchased at bodegas, supermarkets and pharmacies, if a person could afford them.[155] Many, however, reported that they could not afford to purchase supplies and had resorted to wearing several panties, towels and sheets. Some girls said they received supplies from international NGOs, including hygiene kits, but the supplies were inadequate and they wanted to receive free pads.[156] A lack of menstrual hygiene supplies was perceived as a possible risk factor for survival sex for women and girls who could not afford them.

"Most women have to go to Jacmel to buy them but it is difficult since they don't have money."

Female focus group discussion participant, Jacmel.

Recommendations

- All health agencies providing primary health care services should, based on humanitarian standards, ensure that contraceptives are available to meet demand, including condoms, pills, injectables, emergency contraceptive pills and IUDs, as well as long-acting methods and permanent methods, as part of the recovery phase.

- The MSPP, PAHO/WHO and UNFPA should ensure that treatment protocols for syndromic management of STIs are posted, implemented and monitored at all mobile clinics and health facilities.
- All health agencies should inform beneficiaries of the location of existing PEPFAR facilities in each of the 10 departments in Haiti to facilitate community access to HIV/AIDS services, including ARVs.
- The MSPP, with the Health Cluster, should plan to revitalize IEC campaigns about HIV, particularly treatment and care options for all affected Haitians.
- UNFPA should continue to support the distribution of hygiene kits containing menstrual hygiene supplies while exploring options for local production and distribution of menstrual hygiene materials and kits.

Notes

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Annex I: Methods

The assessment examined the level of MISP implementation in Port-au-Prince, Léogâne and Jacmel. The three locations were selected from among 42 sub-national geographic divisions based on criteria that included numbers of displaced persons, level of destruction, accessibility, region category, availability of health facilities and the presence of a humanitarian response. Within Port-au-Prince arrondissement, Port-au-Prince proper, Delmas and Carrefour were selected among the eight communes using similar rationale.

The assessment methods consisted of key informant interviews, facilities assessments and focus group discussions with displaced populations. In total, the team met with 41 staff, comprising RH coordinators and representatives from UN agencies, local and international NGOs, the Haitian Ministry of Health and the Haitian Ministry of Public Health. In-depth interviews were conducted with 34 staff from 21 agencies. Ten facility assessments were conducted for nine agencies to examine service availability. Fourteen focus group discussions with 329 displaced men, women and adolescent girls and boys were convened to gauge community perspectives.

The teams used pre-existing RHRC Consortium data collection tools to conduct the in-depth interviews, facility assessments and focus group discussions. Prior to the assessment, the tools were reviewed to reflect the 2010 revised *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* chapter on the MISP, and related data collection instruments, including the Health Cluster's Health Resources Availability Mapping System (HeRAMS) and the CDC's draft self-response MISP implementation survey. All tools, with the exception of the focus group discussion guide, were translated into French and Creole by professional translators. The focus group discussion guide was translated into Creole.

CDC assisted in the random selection of health facilities for the facility assessments. The sampling frame was a list of 128 health agencies and functioning referral facilities, which were obtained through CDC's Haiti office and the Health Cluster's hospital working group. For Port-au-Prince proper, six out of 20 facilities were randomly selected, while in Delmas six, and Carrefour five were selected. In Léogâne and Jacmel, given the limited number of fixed health facilities, all four and all three facilities were selected, respectively. The actual numbers visited were: one hospital in Delmas; two hospitals and one mobile clinic in Port-au-Prince; two field hospitals and one camp clinic in Léogâne; and one referral hospital, one dispensary and one mobile clinic in Jacmel.

Focus group discussion sites were selected primarily through convenience sampling. Purposeful sampling was used to select participants, with the help of NGOs or camp committee members. Explicit considerations were made to ensure to the extent possible that displaced women, men and adolescents resided in various locations if in a camp and represented differing vulnerabilities. Separate focus group discussions were held with women and with men. The age of adolescents ranged from 10 to 25, depending on the group. All discussions were conducted either in English with Creole translation or in Creole only. Participants were informed of the purpose, process and use of information; the assessment team's commitment to respect confidentiality; the importance of participants' respect for confidentiality among the group; and their right to refuse to participate, to leave or to remain silent. Group consent was obtained and, where possible, Creole translations of the Women's Refugee Commission's work and contact details were provided to participants through a one-page fact sheet. Written or verbal consent was also obtained from interviewees for in-depth interviews and staff at health facilities for the facility assessments.

All data were analyzed in English. They were further triangulated and findings verified with past assessments conducted by other agencies and available information sources.

Limitations

This assessment had several limitations. Time was an issue regarding interviews, as not all relevant staff were present and available for meetings at the time of the assessment. Some agencies were no longer present, which limited access to retrospective questioning of services provided. Security restrictions for travel to certain communes also restricted access to potential interviewees, although in some instances, phone interviews were possible.

While the intention was to visit all facilities in the randomly selected pool for each arrondissement, this was not entirely feasible due to security restrictions, distance between selected sites and non-response to a request for a visit by several target facilities. The health agency list to which the team had access was dated mid-April and also listed by agency rather than facility; hence, it was impossible to locate and sample every mobile facility that tended to have an ad hoc presence. Given practical challenges, the teams attempted to visit different types of health facilities (referral hospital, standing health facility, mobile clinic, etc.) to the extent possible in each of the three arrondissements.

Limitations for focus group discussions included: nonrepresentative sampling, translation error and the possible lack of consistency, limited number of sessions per site resulting in potential lack of saturation, time constraints hindering access to very remote communes, and in Port-au-Prince, disruptive sessions due to rogue men in the communities. Moreover, while the majority of groups were separated by participant age, this could not always be guaranteed given the logistics of organizing the groups.

Nevertheless, younger participants were contributing sensitive information to mixed discussions; it is unknown to what extent, if indeed, the wider age ranges compromised quality. The translators for the Port-au-Prince team were male and it was unclear whether this had any repercussions on data quality of the focus group discussions with women and girls. Lastly, the teams were not able to meet with persons displaced within communities; hence, the data do not capture the situation of displaced persons absorbed into host communities.

Annex II: Select reproductive health policies obtained through desk research (not exhaustive)

- Plan Interimaire du Secteur Santé Avril 2010-Septembre 2011 (MSPP, 2010)
- Growth and Poverty Reduction Strategy Paper 2008-2010 (MPCE, 2007)
- National Strategic Plan for Health Sector Reform 2003-2008 (MSPP, 2004)
- Politique Nationale de Santé des Jeunes et des Adolescents (MSPP, 2001)
- National Health Policy (MSPP, 1996, revised 1999)
- Manuel de Normes de Prise en Charge Clinique et Thérapeutique des Adultes et Adolescents vivant avec le VIH (MSPP, 2008)
- National Plan of Action to Combat Violence against Women, Prevention, Treatment and Support for Victims of Violence against Women 2006-2011 (Concertation Nationale contre les violences faites aux femmes, 2006)
- Fiche Technique: Prise en charge des victimes de violences sexuelles (MSPP, 2006).
- Plan stratégique national pour la prévention et le contrôle des IST et du VIH/SIDA en Haiti 2002-2006 (MSPP, 2002)

Annex III: Reproductive Health Indicators in Haiti

	National	Port-au-Prince (Ouest)	Artibonite	Centre	Grand' Anse	Nippes	Nord	Nord-Est	Nord-Ouest	Sud-Est	Sud	Source
Population	9,923,242	3,664 623	1,571,020	678,631	425,877	311, 496	970,489	358,277	662,778	575,292	704,759	CDC (2009)
Births expected (2009)	298,893	109,939	43,674	26,806	12,904	9,937	28,144	12,719	20,082	16,223	18,465	CDC (2009)
Maternal Mortality Ratio: maternal deaths per 100,000 live births	630 (670)											EMMUS IV (2007) (WHO 2007)
Infant Mortality Rate per 1,000 live births	57											EMMUS IV (2007)
Total Fertility Rate	4.7 (3.5)											EMMUS IV (2007) (UNICEF 2008)
Contraceptive Prevalence (modern method) (percent)	24.8%	27.4 (22.4)	29.5	20.1	28.6	27.2	23.1	27.0	21.2	12.9	26.7	EMMUS IV (2007)
Unmet need for family planning (percent of currently married women, 15-49)	37.5											DHS (2005-06)
Births attended by trained personnel (percent)	26.1	50.1 (25.9)	21.6	14.2	15.1	12.9	23.4	30.8	25.9	12.5	23.7	EMMUS IV (2007)
Adult HIV Prevalence (percent)	2.2	2.4 (2.0)	2.1	1.6	1.6	3.0	2.9	2.7	2.0	1.4	2.2	EMMUS IV (2007)

Sources: Cayemittes, M., Placide, M., Mariko, S., Barrère, et al. (2007). Enquête Mortalité, Morbidité et Utilisation des Services (EMMUS-IV), Haïti, 2005-2006. Calverton, Maryland, USA: Ministère de la Santé Publique et de la Population (MSPP), Institut Haïtien de l'Enfance (IHE), and Macro International Inc.; UNICEF (2008) Statistics: Haiti. Retrieved on May 15, 2010 from: http://www.unicef.org/infobycountry/haiti_statistics.html; Haiti Demographic and Health Survey 2005-2006, Macro International (2007). *Maternal Mortality in 2005: estimates developed by WHO, UNICEF, UNFPA, and the World Bank. Geneva*: WHO; CDC (2009). *Rapport Enquete Sonu: Enquete Sur Les Soins Obstetricaux et Neonataux d'Urgence en Haiti* (MSPP/UNFPA).


care


IPPF
International
Planned Parenthood
Federation
East & South East Asia and Oceania Region


Save the Children
USA


WOMEN'S
REFUGEE
COMMISSION