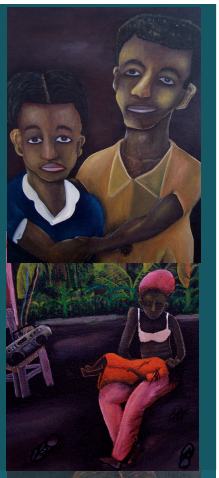
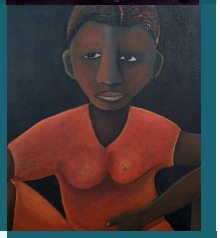
The Long Wait

Reproductive Health Care in Haiti





"If you wait all day, you probably won't be seen. So you go back home, deliver, and watch your baby die."

-Woman from Port-au-Prince, Haiti

JSI Research & Training Institute, Inc.

Cover photo: Women in Cité Soleil, Port-au-Prince, Haiti.
Cover art: Artist co-op, Jacmel, Haiti

All photographs: JSI/Molly Fitzgerald and JSI/Erika Larson

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MISSION STATEMENT

JSI's Reproductive Health for Refugee's Project works to increase access and availability of quality reproductive health services for populations affected by crisis. We believe an integral part to achieving universal access to comprehensive reproductive health, especially among those affected by crisis, is to build networks and the technical and organizational capacity of local non-government organizations that provide services before, during, and after the crisis.

JSI and its staff are dedicated to improving the health of individuals and communities throughout the world. We believe that all people are entitled to accessible, appropriate quality health care. To make this vision a reality, JSI applies practical and innovative solutions in management, research, education, information, and training.

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ACRONYMS

AED	Academy for Education Development
AFD	Agence Française de Développement
AOPS	Associations des Oeuvres Privées de Santé
ASRH	Adolescent Sexual and Reproductive Health
CIDA	Canadian International Development Agency
CRAD	Centre de Recherche et d'Action pour le Développement
CRS	Catholic Relief Services
EmOC	Emergency Obstetric Care
FOSREF	Fondation Pour La Santé Réproductive et L'Education Familiale
GBV	Gender-Based Violence
INGO	International Non-Governmental Organization
JSI	JSI Research & Training Institute, Incorporated
MARCH	Management and Resources for Community Health
MDM	Médecins du Monde
MISP	Minimum Initial Services Package for Reproductive Health in Crisis Situations
MOH	Ministry of Health
MSF-B	Médecins Sans Frontières Belgium
MSF-H	Médecins Sans Frontières Holland
MSH	Management Sciences for Health
NGO	Nongovernmental Organization
PEPFAR	President's Emergency Plan for AIDS Relief
STI	Sexually Transmitted Infection
UNICEF	United Nation's Children's Fund
UNFPA	United Nation's Populations Fund
URAMEL	Unité de Recherche et d'Action Médico Légale
USAID	United States Agency for International Development
WHO	World Health Organization

MAP

Map No. 3855 Rev. 4 UNITED NATIONS. June 2008. Department of Field Support. Cartographic Section.

EXECUTIVE SUMMARY

Haiti is a vibrant, resilient country with a rich cultural and political history. Natural disasters and political violence have exacerbated economic and social conditions, presenting Haiti with burdensome challenges. However, the country continues to emerge from these crises with determination to confront the deteriorated capacity, infrastructure, human resources, and systems of health service delivery, including those related to reproductive health (RH).

Though Haiti is home to communities bound together in a rich culture, it is the poorest nation in the Western Hemisphere. In addition to a historically volatile political climate, Haiti's communities live in some challenging health circumstances. The reproductive health status of Haiti's communities contributes to a life expectancy of 62.8 years for women[1] in comparison to 75.5 years in neighboring Dominican Republic[2] or 80.8 years for women in the US.[3] According to Haiti's 2005-2006 Demography Health Survey, 37.5% of women have unmet family planning needs.[4] Additionally, youth and rural area residents report greater unmet needs for family planning than the national average.[5] Unmet family planning contributes to a high total fertility rate of 4.79 (5 in rural versus 2.8 in urban areas),[6] a high infant morality (57 deaths per 1000 live births) and the highest maternal mortality rate in the western world– 630 deaths per 100,000 live births.[7]

These alarming RH indicators prompted a team from JSI Research & Training Institute, Inc. (JSI) to visit Haiti in January 2009. The objectives of the study were:

1) to identify gaps in the availability and accessibility of comprehensive RH services including:
   - Safer motherhood and emergency obstetric care (EmOC)
   - Family planning
   - HIV/AIDS and sexually transmitted infections (STI) prevention, care and support
   - Gender-based violence (GBV) prevention, care and support
   - Adolescent-focused RH programming for each of the above RH components

2) to identify community-level responses and opportunities for strengthening the quality and availability of comprehensive RH services.

This report presents the findings of this assessment.

Summary of Key Findings

1) **Comprehensive RH care in Haiti remains generally inadequate even during the non-emergency period**, despite the reproductive health services provided by relatively well-resourced emergency NGOs in limited locations.

2) **Family planning (FP) access in Haiti is particularly lacking.** Since the 1970s, FP has been inconsistently supported. Today, challenges persist: unmet need is high, and commodities are urgently needed, especially in light of a broken supply chain system; access to quality services remains inadequate for the demand; remote areas have a limited availability of methods, especially long-term methods; and geographic gaps are scattered throughout the country. In particular, quality adolescent family planning services are insufficient to meet the need in many areas.

3) **A fine balance between building local capacity and providing quality services has been hard to strike in Haiti** where investments in the public health system and Haitian NGOs are often relinquished for funding allocations to international NGOs that provided needed quality RH services during crisis.

4) **A number of promising Haitian organizations that provide RH-related services are well in-tune with the community's needs.** These local NGOs often address RH needs in the way women experience them, holistically. While these organizations operate on relatively small budgets, many of these groups are often overlooked by donors in favor of familiar international NGOs with large-scale funding requirements and quick-impact programming.

5) **Indirect costs such as transportation expenses, long periods of waiting, and poor or absent care due to health worker shortages and strikes inhibit many women from accessing free services.** Free services, especially those related to safer motherhood and emergency obstetric care, contribute to the Ministry of Health's priority to reduce the maternal mortality rate. However, reaching women, especially those who cannot afford these indirect costs, has been difficult.

Cité Soleil, a slum in Port-au-Prince, Haiti

Key Recommendations

- **Allocate More Funding for Reproductive Health Services Before, During, and After Emergencies.** Donors and the Haitian government should increase the pool of available funds to cover all areas of reproductive health, especially family planning which has been inadequate in rural areas and during times of crisis. Funding should be sustained after crises to ensure continuity in services.

- **Adapt Better Funding Mechanisms.** Existing funding structures should adapt to bridge the service and funding gap in reproductive health between relief and development. Short-term funding, largely given to international NGOs, undermines long-term development capacity building. Better coordination among not only donors, but also relief and development actors is necessary in order to strike a balance between providing essential, quality services and strengthening the framework for long-term development programs.

- **Support Local Leadership for a Coordinated Response.** The international community should prioritize financial and political support for local NGOs and Haitian government public health officials to lead a coordinated, comprehensive model that addresses crisis and development. More investment should be made in local capacity and the Haitian public health budget in order to meet ongoing public health demands before, during, and after a crisis.

- **Make Community Level Investments.** More investments at the community level should be made to reduce the unsustainable burden on general hospitals. Some of the most effective organizations are Haitian NGOs that operate on relatively small budgets and are well-positioned to address primary healthcare needs, thus alleviating the stress on tertiary care facilities. Because local groups are well in-tune with the community, they address reproductive health needs in the way that women themselves experience them, holistically. Haitian NGOs are not easily defined as HIV *or* family planning organizations or compartmentalized as relief *or* development actors. These organizations are often overlooked in favor of short-term, large-scale funding for international NGOs. Because local actors are often first responders, they are well-placed to provide the Minimal Initial Service Package (MISP) for reproductive health in crisis situations, and also remain long after a crisis to provide continuity in services for the community. These invaluable human resources should neither be overlooked in times of crisis nor beyond.

- **Support Holistic, Integrated Models for Comprehensive RH.** More investments in funding and training should be made in family planning and adolescent sexual and reproductive health. These two components are not as well resourced as HIV, safer motherhood, and gender-based violence. Failure to unite the piecemeal approach will likely result in continued service gaps and mortality. Comprehensive reproductive health can build on the coordination and service infrastructure of initiatives that have succeeded, like HIV prevention. Better integration of the issues that face Haitian women provides an opportunity to close the gaps not only in reproductive health services, but also in economic disparities.

INTRODUCTION

Forty-six nations have been classified as *fragile states*, or nations that "cannot or will not deliver core functions to the majority of its people" because of ineffective or illegitimate governance.[8] Haiti is one of them.

Like many fragile states, Haiti has repeatedly emerged from and descended into crisis. Natural disasters, violence, and declining political, economic and social conditions have been detrimental to not only the fabric of society, but also the capacity, infrastructure, human resources, and systems of health service delivery, including those related to reproductive health (RH).

In comparison to other sectors, health in crisis is often neglected. In the UN Flash appeal for the September 2008 hurricanes[9], health represented only 4% of the total request. Despite Haiti's high maternal mortality ratio in non-emergency periods (the highest in the Western Hemisphere), the request for lifesaving RH services such as "safe deliveries for pregnant women who have lost access to basic health services by the hurricanes" only amounted to 3.5% of the health request and 0.1% of the overall appeal. As of March 2009, the amount was not fully met. This support pales in comparison to the 31% of the overall appeal allocated for food aid.

Although humanitarian relief organizations aim to provide critical RH services *during* crisis, a remarkable gap in funding and services emerges between the crisis period and long-term development. While this phenomenon is found in many crisis areas around the world, the relief to development gap is particularly evident in Haiti where the annual hurricane season bares down on the deteriorated health system and continues to drive the reliance on international NGOs for service provision.

After a prolonged endeavor to become the first independent black nation, Haiti has faced political instability and extreme poverty. Haiti's decaying infrastructure and lack of resources have made the country particularly vulnerable to the effects of natural disasters such as floods, mudslides, and hurricanes.[10] Despite its proximity to wealthier developed countries, Haiti remains the poorest country in the Western Hemisphere.

With 34 deaths per 1000 live births, Haiti's neonatal mortality rate is the highest in the Western Hemisphere and among the highest in the world.[11] According to the most recent Demography and Health Survey (2005-2006),[12] 37.5% of women 15-49 years have unmet family planning needs, leading to a high total fertility rate of 4.79 (5 in rural versus 2.8 in urban areas). Infant mortality is recorded at 57 per 1000 live births, and maternal mortality is the highest in the western world with an estimation of 630 deaths per 100,000 live births.[13]

Selected Reproductive Health Indicators			
	Haiti	**Dominican Republic**	**United States**
Life expectancy at birth (women, years)	62.8[14]	75.5[15]	80.8[16]
Maternal Mortality Ratio: maternal deaths per 100,000 live births	630 per 100,000 live births[17]	150 per 100,000 live births[18]	14[19]
Infant Mortality Rate (under 1 year, per 1,000 live births)	57[20]	31[21]	7[22]
Total Fertility Rate	4.79[23]	2.8[24]	2.1[25]
Unmet need for family planning (women 15-49 years)	37.5%[26]	11%[27]	Not available
Births attended by trained personnel	26.1%[28]	98%[29]	99%[30]

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.

OBJECTIVES

A team from JSI visited Haiti in January 2009 to assess reproductive health (RH) services in the country. The assumption was that there must be a level of community resilience, despite tremendous needs arising from a context of political, economic and natural crises and a consequential reported reliance on external actors. The overarching goal of the assessment was to understand whether this was in fact the case, and if so, what impact crisis and community response had on the accessibility and availability of RH services. Specific objectives were 1) to identify gaps in the availability and accessibility of RH services and 2) to identify community-level responses and opportunities for strengthening the quality, accessibility and availability of comprehensive RH services. The investigating team further sought to learn from Haiti's experience in dealing with chronic crises. Understanding Haiti's experience during this time of relative stability could inform future crisis responses in Haiti and elsewhere.

METHODOLOGY

With these goals, the investigation focused on the crisis response of the international and local actors in Haitian communities. The team made a concerted effort to identify and interview those involved in community-based initiatives, particularly Haitian nongovernmental organizations (NGOs), in addition to a range of other humanitarian and health actors including representatives of the Ministry of Health, international nongovernmental agencies, health service providers, donor agencies and community members. The organizations and individuals interviewed were identified through in-depth discussions with public health experts, public health organizations and an internet-based search of organizations working on reproductive health and/or women's issues in Haiti. The initial list was expanded through a snowball technique whereby additional groups were solicited during each interview.

LIMITATIONS

An effort was made to draw on as many perspectives as possible. However, the relatively short time frame and logistic constraints limited the number and diversity of groups consulted. The initial plan had been to visit several more remote areas, but a fuel crisis that occurred during the two-week visit precluded extensive travel outside Port-au-Prince. The team was only able to visit the southeastern region of Miragoâne, Les Cayes, and Jacmel. In Port-au-Prince, the team visited communities in Martissant and Cité Soleil in addition to organizations and health facilities in greater Port-au-Prince. Language limitations of the authors also influenced the discussions. In cases where French could not be used, impromptu interpreters helped. In these instances, some information may have been lost or inadvertently changed in the translation. While this report does address broader social, political and economic issues as they relate to reproductive health needs and services, the assessment itself did not explore these issues in depth.

FINDINGS

REPRODUCTIVE HEALTH POLICY ENVIRONMENT

Ministry of Health (MOH) officials recognize that there are many critical health care and RH needs in Haiti. Reducing the alarming maternal mortality rate remains a stated priority of the MOH, international donors and NGO community. The national RH strategy framework has been formed around particular RH components that correspond to funding availability. This national response involves a multi-pronged strategy for family health, including:

- **"Reduction of Maternal Mortality" program (RMM)** is financed by the Canadian Development Agency (CIDA) in the Northern provinces and by Agence Française de Développement (AFD) in the South.

- **"Soins Obstétrique Gratuits" (SOG)**, also a Canadian supported endeavor, is a free obstetric care program to encourage facility-based births in

lieu of home births that often occur without a trained traditional birth attendant or midwife.

- **"Repositioning Family Planning"** is funded by United States Agency for International Development (USAID) with a focus on support to family planning services (strengthening quality, supply management systems and counseling) in 152 of Haiti's existing 752 health service delivery sites.

- **HIV programming, including the Prevention of Mother to Child Transmission (PMTCT)**, is offered in 93 sites and is mostly funded by the President's Emergency Plan for AIDS Relief (PEPFAR) and contributions from the United Nations Children's Fund (UNICEF). Between 2003 and 2004, clinics were upgraded for improved prenatal care, and a number of the government maternities were rehabilitated.

Although the policy environment for RH in Haiti generally remains favorable for safer motherhood, an obstetrician gynecologist from one large international NGO reported that 30% of maternal deaths in the Port-au-Prince facility stemmed from spontaneous or unsafe induced abortions. Still, abortion remains illegal for both doctors and patients, and family planning has been a challenge because of inconsistent support in the last three decades. On the other hand, over a decade has passed since the last prosecutions for abortion occurred, and it was widely agreed that the current conservative laws do not reflect the progressive political environment.

In spite of the MOH's fairly comprehensive national strategy for safer motherhood and a relatively favorable policy environment for RH in Haiti, donors largely determine what policies are translated into programming. The national strategic plan, as it is outlined by the MOH, is essentially 100% donor-supported, and priority components appear to be defined in terms of the funding. This appeared to be a frustration of Haitian health officials, who had the challenging task of balancing the need to coordinate a wide range of stakeholders including donors with varying agendas. Unfortunately, priorities and donor funds do not always correspond, and the programmatic response always seems to fall short of the need.

Adolescent health and sex education was mentioned as a government priority; however actual programming was insufficient to meet the need. Unlike the other prongs of the strategy, the MOH official did not mention a particular funding stream to provide adolescent RH and the national budget seemed insufficient to fund such an endeavor. Additionally, while sex education is theoretically addressed in school curriculum, we were told this was not the case. NGOs often support peer education including referrals and sensitization about Gender Based Violence (GBV). For example, Médecins du Monde (MDM) provides psychosocial support and free medical certificates to rape victims. Adolescent sexual and reproductive health services (ASRHS) are being provided by relatively few NGOs, though achievements in ASRHS will be required for successful HIV prevention and advances in other priority areas.

"Everything in reproductive health is a gap."

- Haitian public health NGO manager

ACCESS AND AVAILABILITY OF REPRODUCTIVE HEALTH SERVICES

RH access and service availability are addressed in the following sections. The assessment team was interested in Haiti's "crisis response" for RH, and, in addition to inquiring about service provisions, the team asked each of the respondents about their response to hurricanes and other crises. It became clear that the repeated bouts of floods and political violence in Haiti (in addition to daily incidences such as fuel crisis demonstrations) make it difficult to demarcate the end of crisis in Haiti. Theoretically, Haiti could be considered a country transitioning from crisis to development. However, one public health official explained that this was not so, that, in fact, "every day is a crisis". The findings detailed below should be understood within this context.

During Emergencies: The Minimal Initial Service Package (MISP) for Reproductive Health in Crisis Situations

Among many actors that were interviewed, it was evident that RH is not specifically identified as a priority in crisis response. The overwhelming reaction when asked about crisis response was that everyday is a crisis. Little was known about the Minimal Initial Service Package (MISP) for Reproductive Health in Crisis Situations,[31] and of the few agencies that were familiar with the MISP, one responded that the package was more useful and relevant during non-crisis than in times of crisis, implying that Haiti was striving for minimum RH services even without disaster at the door.

> *"Every day is a crisis."*
>
> -Haitian public health official

With the exception of comprehensive RH services provided by relatively well-resourced emergency NGOs in limited locations, comprehensive RH care was inadequate even during the non-emergency period when the assessment took place.

Safer Motherhood and Emergency Obstetric Care

In spite of the challenges for ensuring basic initial services in the midst of crisis, the MOH acknowledged safer motherhood and the provision of emergency obstetric care (EmOC) as a priority. The government's commitment is supported by training and services provided by a number of large donors including USAID, CIDA, and AFD.

The international community also provides direct services. For example, the Cuban government provides a range of generalist and specialist care providers who are critical to EmOC and safer motherhood. Médecins du Monde (MDM) provides comprehensive, quality RH services in one Port-au-Prince location. These services were comprehensive and free. The MDM doctor pointed out that the services were temporary. In spite of being relatively well-resourced, the MDM facility was unable to accommodate the client load each day because of the shortage of RH services elsewhere in the city. Médecins Sans Frontières-Belgium (MSF-B) reported that Médecins Sans Frontières-Holland (MSF-H) handles 60% of all obstetric emergencies in Port-au-Prince.

Meeting monthly, the MOH, World Health Organization (WHO) and other key experts take part in a national task force for the reduction of maternal mortality. Major donors support key activities such as the provision of EmOC (CIDA supported) and efforts to strengthen midwife training by updating protocols and standards.

Availability of services is uneven, inadequate and short-term. Despite the work of 450 NGOs and other public and private services throughout the country, many remote areas do not have adequate RH services. One Haitian NGO director pointed out that most NGOs tend to base themselves in the main towns where other NGOs are already present.

Coverage and availability of services related to safer motherhood cover only 152 sites (of over 700) in the 10 country departments. In partnership with USAID, Management Sciences for Health (MSH) provides training at these sites for the case management of safer pregnancies and deliveries. Since 80% of deliveries

TREACHEROUS JOURNEY TO DELIVER

A local NGO reported that during the hurricane season, the Artibonite River floods, isolating the South from the North. Every year, buses and trucks attempt to make the trip across the river, often resulting in fatalities.

A regional hospital noted because of impassable, flooded roads, a woman in labor has only one choice—to take a treacherous boat ride to access critical medical care.

take place in homes, MSH also plans to train traditional birth attendants (TBAs). The 24 week-long course (1 day per week, 3-4 hours per day) has a curriculum that includes family planning. The course is being revised to include recommendations to support the Preventing Mother to Child Transmission (PMTCT) program, such as referring patients to clinics within 72 hours of deliveries.

Inadequate investments in integrating comprehensive RH into primary healthcare have further burdened under-resourced tertiary facilities that lack equipment, drugs and doctors. Short-term international donor support for crisis does not match Haiti's long-term needs. Short-term emergency funding supports many INGOs that provide the majority of maternity and EmOC services. INGOs are far better resourced than public facilities, and because these INGOs are well supplied, relatively better staffed, and provide free services, their facilities attract a larger caseload. The resulting reliance on INGOs to provide services in limited areas is not nearly sufficient for the demand for services.

Difficult and delayed access continues to hinder adequate care. In spite of a political commitment to reduce the maternal mortality rate, an array of interrelated issues hinders the ability and/or motivation of women to seek care, often leading to delays in care. Ministers of Health, international NGO workers, and health service providers echoed the reality of the 'three delays' including seeking care, reaching a health facility, and receiving adequate care once a facility is reached.[32] In Haiti, these barriers to accessing safe childbirth also include economic hardship, transportation barriers and the challenge of reaching a facility that can handle deliveries. According to the manager of a large INGO, there is also a delay in seeking prenatal care. While he cited that 70-80% seek prenatal consultations, women generally wait until the 3rd trimester to see a doctor—precluding opportunities for basic primary healthcare for the mother throughout the pregnancy.

Although services are "free" for pregnant women, access to care requires travel expenses and other opportunity costs; in addition to these expenses, expectations of care are poor at most public facilities. Even for women who can afford to pay the cost of transportation to the hospital itself, the motivation to do so is hindered by expectations of poor care at the public health facilities. Expectations of poor care were informed by instability, frequent healthcare worker strikes, a general shortage of healthcare workers, long wait times, and a lack of supplies or supplementary materials such as gloves and syringes. At one public facility, the nurse explained that bed space was so inadequate that many of the women lie on the floor.

Combined with issues of cost, tendency for home deliveries remains a barrier to the success of the safe motherhood program. Given the direct and indirect costs associated with hospital deliveries, 70% of births take place at home. Though there is a cost in using a traditional birth attendant, the fee is usually higher in Port-au-Prince than in rural areas. For this reason women often travel to their mother's home in order to access social support needed for the delivery. INGOs provide free obstetric care, however, some women without an urban support network still opt to pay transportation costs to travel to rural areas because INGOs are often crowded and wait times are long.

"If you wait all day, you probably won't be seen. So you go back home, deliver, and watch your baby die."

-Woman in Martissant, a slum in Port-au-Prince

During times of violence and crisis, women reported being afraid to leave their homes to seek care. The prevalence of home deliveries increased during crises. Fear of rape often inhibits women from seeking the care they need, including safer deliveries by a trained healthcare worker.

Family Planning

Donor pledges and support for reinvigorating family planning efforts have recently emerged. The Haitian MOH and USAID have declared a renewed

commitment to FP. USAID supports family planning service strengthening in 152 of 752 service sites, and it is unclear if a plan exists for the MOH to undertake and sustain this effort. USAID recognizes the link between FP and maternal and child health stating, "Ensuring that postpartum women have access to high-quality postpartum services, including family planning and counseling about birth spacing and limiting options, is an important strategy in reducing both maternal and early childhood mortality rates."[33]

Family planning coverage is spotty and inadequate. All 10 of the departments in Haiti have FP programs, but quality and access across sites within these departments is inconsistent. MSH implements USAID projects in 152 service points by partnering with the MOH, public institutions, government hospitals, and NGOs including JPHEIGO. Population Services International (PSI) also has a large social marketing program for the promotion of pills and condoms. According to MSH, the new approach to FP will emphasize greater community involvement, including the training of community workers to enhance the availability of methods in rural areas.

Efforts are underway to improve the national drug supply and commodity system. This is an urgent priority. There is a need for strengthening the supply chain system; the lack of reliability has been a tremendous barrier to the availability of a consistent supply of family planning commodities in Haiti, particularly farther along the supply chain in rural areas. During the assessment, supplies were obtained from a central depot, but stock-outs were frequently reported at local service-delivery points.

With high levels of funding, condoms have successfully been promoted for HIV prevention. In light of the successful promotion of condoms for HIV/AIDS prevention, an opportunity exists to promote condoms as a family planning method. During the course of an informal discussion with residents of Cité Soleil, young men participating in the conversation said condoms were widely accepted for the prevention of sexually transmitted infections. Though extensive resources and aggressive social marketing have contributed to the acceptability of condoms, family planning promotion has not been approached in the same way.

Since the 1970s, family planning has been supported inconsistently in Haiti. During an interview, an MOH official introduced a new strategy to reposition FP. However, the 'new' "Repositioning of FP" program is not in fact new. Haiti has initiated similar attempts in the past, but these programs experienced variable success and support over the past 60 years. In fact, family planning was much more successful in the 1970's when the MOH had a division dedicated to FP. As one medical doctor and director of a large Haitian NGO explained, despite slight success in the 1980s when the contraceptive prevalence rate (CPR) was 35%, it declined during the 1990s. As resources were diverted to HIV in the 1990s, FP resources dwindled, and the use of FP declined. Today, the CPR has dropped to 26%.

"The family planning program is not really working that well…there is a need for other methods besides pills. [Lack of] community mobilization, access, and availability are problematic."

- A government health official

Several authors have analyzed the perplexing divergence between the investment in FP and success in FP programming.[34] There are numerous explanations for why FP has not succeeded in recent years, and many agree with the notion that FP failures have directly correlated with the competing, larger investments in HIV. The MOH suggested that in spite of the large investment by donors and NGOs for FP in Haiti, "some have big financing and small effectiveness." Theories aside, it remains clear that the availability of family planning services has suffered from the inconsistent commitment to family planning.

A discussion with two representatives from a Haitian RH NGO that had FP funding in the past from the Gates Foundation, offered a typical illustration of disproportionate resources for HIV in comparison to family planning. Because HIV funds are more readily available and FP funds have dried-up, the organization lost its incentive to prioritize comprehensive FP services. The NGO described FP and CRH as being "on the backburner in terms of finance." Now that PEPFAR funds their programs, they have maintained their prevention of early pregnancy but have discontinued comprehensive FP services. A number of other organizations that formerly worked in FP were also cited as moving into HIV, including two large INGOs that were previously known for their FP programming.

"We'll never finish with sexually transmitted infections and HIV/AIDS unless we address family planning. We need to allow women to have the number of children they want."

-Medical doctor and director of Haitian NGO

Additional institutional barriers include the compartmentalization of RH from other basic needs. One Cité Soleil resident and development organization community worker suggested that the United States' government and the UN have recognized the links between health and security in terms of HIV, but not between security and comprehensive RH. Because the RH needs are not often talked about in terms of education, poverty, and security, RH can easily be forgotten. He went on to say that an emphasis on family planning services would reduce the burden on women and families; they would have fewer children to educate, women and girls would be less vulnerable to sex work, and communities would be less vulnerable and disposed to violence. The NGO worker and community members described the need to address these issues as interrelated issues, not as distinct topics that are addressed in isolation by separate programming components.

Incomplete coverage and availability of limited family planning methods have hampered the success of programming. The demand for quality RH services is immense in urban areas. FOSREF, an organization that reported that they provide 25% of family planning services in Haiti, has documented that most of their family planning users are in urban areas. National population surveys concur that actual family planning users are concentrated in urban areas. However, unmet need is higher in rural areas because access to information and to contraceptives is not readily available.

According to the MOH and other health NGO workers, geographic gaps are scattered throughout the country – the Northwest, Grand Anse, Nippes, Petit Troups de Nippes, Mole Saint Nicolas, and Belle-Anse. Rural and remote areas have a limited availability of methods, especially long-term methods.

Improving access in rural areas requires improving availability of commodities in-country and strengthening the supply chain system at all levels. Many NGOs said the supply system is broken and commodities often do not reach service-delivery points. Some claimed that family planning supplies were being diverted to the Dominican Republic to be sold for profit. Ironically, the research team was also told that many Haitians crossed the border to the Dominican Republic to access supplies and services. The UN, Haitian government and nongovernmental public health workers cited supply chain challenges such as shortages in rural areas. Women confirmed that it was difficult to access a full range of methods. One NGO manager in the southern region explained that the central departmental depots store all of the FP supplies, which are to be distributed within the department's service sites. However, because adequate supplies are not ordered or are late to arrive, depot officials come to NGOs for these critical supplies.

Though mismanagement at the provincial level contributes to the lack of supplies, broader transport and costs issues also play into the under-stocking of FP supplies. One NGO worker with extensive facility

management experience explained that when trucks load supplies from Port-au-Prince, drivers give preference to more profitable commodities. FP methods that will be sold at low cost or given for free are left at the warehouse in favor of antibiotics that sell quickly at a higher price. Because commodities are centrally supplied and subsidized 100% by external donors, stock-outs were widely reported, and essential services were reportedly strained or halted.

Both service providers and users reported the medicalization of family planning. Government and nongovernmental health officials reported the need to mobilize and raise awareness about family planning at the community level. Cité Soleil residents supported this view saying, family planning and other RH services are available at a hospital currently operated by MDM. During recent crises, mobile clinics provided health care services, including RH. While condoms were made available, other family planning methods had to be obtained at the hospital.

The demedicalization of FP would alleviate some of the burden on highly trained doctors and nurses. With the exception of PSI's social marketing program for condoms and pills throughout the country, very little community-based distribution was available for many methods. There is a need for more training of community-level health workers with strong links to clinics in order to assure more consistent access to a range of family planning methods.

HIV Programming Including Prevention of Mother to Child Transmission

The robust investment in HIV programming has had significant success. Within the past five years, the HIV prevalence has declined from 5.6% to 2.2%.[35]

Investments have also contributed to a 12% increase in the use of male condoms, now estimated at 24%. PMTCT is offered in 93 sites, most of which are PEPFAR funded. In 2003-2004, many of the government maternities were rehabilitated and upgraded with PEPFAR and UNICEF funds.

LOCAL NGO IN ACTION

FOSREF, a Haitian NGO, improves family planning access for youth and rural residents. As a result of high levels of maternal deaths due to teen pregnancies, abortion complications, and HIV infection rates among youth, FOSREF initiated the first youth-friendly facility based services in Haiti.

FOSREF provides a range of comprehensive SRH services for adolescents, including HIV/AIDS prevention programs, STI diagnosis and treatment, sexual and family life education, peer education and radio programming. FOSREF has been a key partner of the MOH and has worked closely with the Minster of Education to implement youth friendly voluntary counseling and testing (VCT) services using peer-based models.

Access to rural areas is enhanced by the provision of FP by mobile clinics. According to FOSREF, they provide 25% of all FP services in the country. Although they do not provide PMTCT, they do provide VCT, condom promotion and training for peer educators in areas where they do not have a facility. FOSREF also has some centers dedicated to services tailored to commercial sex workers.

As part of the national RH strategy, Haiti is developing an HIV protocol and a new general protocol for midwives that handle emergency obstetric care. In 2003, training at the midwifery school reinforced these new protocols for PMCT.

With the growth of investment in HIV, PEPFAR and many other HIV-related actors have been very successful in coordinating with the MOH and the HIV NGO community. This infrastructure of coordination could be extended into other areas of RH to broaden coverage and availability of comprehensive services.

Better linkages are needed between HIV and other RH components including family planning, gender-based violence, and safer motherhood. Without

COMMUNITY RESPONSE

Insecurity and violence during political crisis has taken a toll on community solidarity and trust, repercussions of which often affect women's health and resilience. In spite of these challenges, women in the community continue to rise to the occasion by banding together and reaching out to their neighbors.

A local NGO, CRAD supports a women's center in Martissant, a slum in Port-au-Prince that is notorious for political and sexual violence. The center has evolved over time to address community challenges. The group began when women responded to their own needs after a cyclone left them homeless, exposed, and vulnerable.

After establishing a meeting place at a nearby school, these 5-10 women began organizing their community. Because they too experienced the same challenges, they began to encourage and exchange trust with once skeptical and fearful neighbors. Questions like "How are the kids? How's the home?" slowly evolved into identifying community challenges. First, in the 1990s, the group addressed their children's education. Then, after a *coup d'état,* they began to organize around protecting women from rape and violence by creating a system by which they would accompany women walking in the slum streets. Today, with a group of mostly single parents this women's group is focused on building capacity within their communities to bring their neighbors out of poverty and violence.

more investment in family planning and improved access for safer motherhood, PMTCT will continue to pose a challenge for effective HIV programming.

HIV services are costly, and the current investments may be difficult to sustain over the long-term. Current levels of HIV prevention and treatment are high, but the funding has been mostly external. There is a profound need to find a sustainable, local investment to address Haiti's HIV prevention and treatment needs.

Gender-Based Violence (GBV)

GBV efforts are coordinated by a national consortium, which works closely with medical, legal, and psychosocial stakeholders to ensure that survivor needs are addressed. Prevention remains a challenge, and identification and treatment of survivors remains uneven on the ground.

URAMEL (Unité de Recherche et d'Action Médico Légale), a local organization, has been instrumental in strengthening Haiti's response to violence. As one of the lead agencies in the national consortium, URAMEL provides training for case management of survivors of violence. A number of other grassroots organizations that grew out of Haiti's strong women's rights movement are also involved in the consortium and GBV. These organizations are critical in addressing RH on the community level because many of them have garnered community trust and an understanding of the contextual needs of community members.

The approach to violence against women in crisis has been largely reactive. Much of the work done on violence against women has not been integrated with comprehensive RH. In 2005, the consortium developed a national plan, which has progressed; however URAMEL acknowledges there is much to be done. For example, there are only two safe houses in Haiti, both of which are in Port-au-Prince. Illustrating some of the ongoing challenges for the response to violence during crisis, one consortium member pointed to an infamous case of a 4-year-old rape survivor during one of the cyclone crises. The medical and legal processes largely failed in that instance, but the consortium task force

examined the faults in the process, and improvements have been made.

GBV is largely seen as a women's rights issue *instead* of an integral element of overall reproductive health. With the exception of a few local women's groups (see text box), international, national and humanitarian actors mostly have treated gender-based violence as a social issue, or outside the realm of RH. Haitian women that survive violence have a range of needs that must be met; addressing their needs comprehensively requires a holistic approach to services. Isolating 'GBV' from 'other RH' jeopardizes the provision of holistic services. For the most part, Haitian NGOs addressing violence are not considered "health NGOs," and they are disconnected from health funders and the community of comprehensive RH providers. On the other hand, health INGOs usually provide services related to issues of violence such as psychosocial support and free medical certificates for rape survivors who need the documentation for pursuing legal justice.

Crises and instability contribute to the lack of prosecution of perpetrators of rape as related to kidnapping and intimate partner violence. Enforcement of protection laws and prosecutions in rape cases often decline during crisis and instability. Consequently, women become vulnerable to rape either near home with an intimate partner or during kidnappings.

CONCLUSION

Haiti is a lively, resilient country despite its complex political history and propensity to natural disasters. The challenges of providing comprehensive reproductive health services are tough to address in Haiti's volatile and deteriorating political and economic context. These challenges also relate to broader primary care issues, many of which are universal—a shortage in human resources for health, poor training, inadequate infrastructure and supply chain failures. Frequent natural disasters exacerbate efforts to stabilize and strengthen these systems, and although international support for Haiti has been generous in times of crisis, this support has largely been structured for short-term relief.

While this short-term approach has addressed many emergency needs, there are many reproductive health gaps both in and out of crisis. Minimal services for reproductive health are not widely accessible or available to the majority of the population. Even during crisis, the Minimal Initial Service Package was not well known, nor was it available.

The Haitian Ministry of Health demonstrates a commitment to reproductive health, but implementing the national strategy comes at a cost that the government cannot currently afford. A few large donors support the Haitian reproductive health strategy, but donor agendas, on which the national framework is formed, are not perfectly in sync with the needs of the Haitian population.

Family planning and adolescent sexual and reproductive health continue to be under-resourced and neglected. With the increase in HIV funding, fewer organizations focus on family planning and adolescent sexual and reproductive health. Though the Ministry of Health spoke of revitalizing family planning and supporting adolescent sexual and reproductive health, there was no concrete evidence of this commitment during the time of this study. Similarly, the full range of methods for family planning was often not available, especially in rural areas where community health initiatives were deficient.

HIV and gender-based violence were better funded, and the success of these services provides a platform for opportunity to expand and enhance the quality of comprehensive reproductive health. Safer motherhood has also been funded as a priority, but the gaps in family planning, abortion laws and adolescent sexual and reproductive health will continue to hinder success in reducing maternal mortality.

Haiti serves as an example of a country wavering between stability and crisis. The artificially defined responses of 'relief' and 'development' have made coordination, especially between international and Haitian actors, a challenge. Women in need of

reproductive health services have suffered from many of the resulting service gaps. Investments made not only in quality service provision, but also in capacity building for local actors, will help advance priorities to reduce maternal mortality, gender-based violence, HIV, and increase family planning. In a context where political violence, natural disasters, economic deterioration, insecurity, and health are so intertwined, investments in a local and holistic approach is needed to address the needs and struggles of many Haitian women and families.

A Jacmel-based Haitian artist described his vision for the future of Haiti: A rich, complex country, with turmoil violence, and challenging conditions. But the future holds hope and promise, represented by the small bulb of light pasted into his collage.

KEY RECOMMENDATIONS

Donors and the Government of Haiti should allocate more funding for reproductive health services before, during, and after emergencies. Increasing the pool of available funds to cover all areas of reproductive health, including family planning, will help increase availability and access of service. Additional investments should be made in rural areas and during times of crisis. Funding should be sustained after crises to ensure continuity in services.

A greater, integrated investment is needed in reproductive health, particularly for family planning and adolescent sexual and reproductive health initiatives. Even without additional financing, Haiti's less-resourced reproductive health components (family planning and adolescent sexual and reproductive health) could be enhanced by building on the framework of the better-resourced components of reproductive health, like gender-based violence and HIV. Conceptually these services need to be designed in a more integrated, holistic fashion with a goal to address reproductive health needs comprehensively. The component 'piece' approach will continue to result in gaps and mortality. For example, neglecting family planning places a burden on safer motherhood and emergency obstetric care services, which cannot be sustained in the context of inadequate human and financial resources for health.

Donors and implementers should adapt funding mechanisms and response strategies to reflect a balance between short and long-term needs. The health response in Haiti needs to be embedded in a strong understanding of Haiti's political, economic and social context. Haiti and other crisis settings should draw on the lessons learned before, during and after crises. Haiti will have to strike a careful balance between addressing priorities for both immediate and long-term needs. This requires more flexible emergency response models that are not defined as either development *or* crisis.

The international community should support local leadership for a coordinated response. Local actors (NGOs, government public health services) require investments in capacity and finances to be a part of the crisis, transition and development model. Investments will also aid local actors in to meeting ongoing public health demands – during, after and before crisis.

International donors and the Haitian government should make community level investments. While current funding structures make it difficult to bridge the gap between relief and development, much more can be

done at the community level to reduce the burden on general hospitals. Some of the most effective organizations are Haitian NGOs that operate on relatively small budgets. They are well in tune with the community, and they address the needs in a holistic manner, the way that women themselves experience these needs. They are not easily characterized as HIV organizations or relief or development actors. These organizations are often overlooked in favor of short-term large scale funding for international NGOs. However, when these international NGOs leave, the real emergency begins. As first responders, local actors can be well-positioned to provide the Minimal Initial Service Package for Reproductive Health in Crisis Situations, and since they remain long after a crisis, local community organizations can provide continuity in critical reproductive health services.

Within this comprehensive strategy, actors in Haiti should recognize the links between reproductive health, poverty reduction, and security. Investments in poverty reduction strategies, such as microcredit schemes for women, and other broader social and economic development could alleviate some of the access issues faced by the population. However, there is a clear argument that investing in more accessible, comprehensive reproductive health will alleviate many of the economic and social development constraints on women and families in Haiti.

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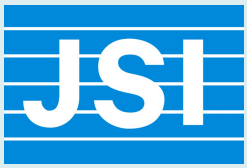

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