Pan American Health Organization
Health response to the earthquake in Haiti: January 2010 - Summary
Washington, D.C.: PAHO, © 2012

Table of contents

1
1
1
2
2
3
12 2010 3
3
4
4
4
4
5
6
6
6
6
6
6
6
7
7
8
8
8
9
9
10
10
11
13

13
13
14
14
15
15
15
16
16
16
16
16
16
17
17

0)39( )9( )8(854(
167 1.4170).
239( )9( )8(2154(
0 37

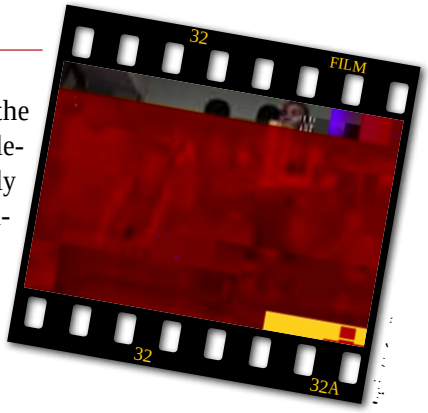
I

is publication sets out the key points of a report published by the Pan American Health Organization, Regional O ce of the World Health Organization (WHO/PAHO), e objective of this report is to draw the lessons to be learned for improving the health response in future sudden-onset disasters, which will inevitably strike one of the many vulnerable countries across the world.

e publication focuses on the rst three months of the response – a critical period during which many errors tend to be repeated.

e authors wish to thank all of their Haitian and international colleagues who shared experiences, information, and views about the health response to what was one of the largest tragedies to ever a ect a nation.

Ha a a [1]



Haiti, an independent nation for over 200 years, shares the island of Hispaniola with the Dominican Republic. e population of around 10 million people is mainly Creole-speaking, with a small more highly-educated French-speaking minority. Approximately 2.3 million people live in the metropolitan capital area (referred to as the Port-au-Prince "agglomeration").

Socio-economic and political situation

Haiti is one of the poorest countries in the world (gross national product per capita of US$850 compared to US$4,860 in the Dominican Republic), and has been classi ed as amongst the most corrupt. Its index of corruption is one of the highest in the world - comparable to that of Pakistan, another country hit by a large-scale earthquake in 2005 (Transparency International 2011).

Haiti has had a turbulent history. A military coup in 1991 led to an international embargo, military intervention, and nally the disbanding of the army. In 2004, the United Nations established a peace-keeping force, MINUSTAH,[2] which played a key role following the 2010 earthquake.

State institutions are weak and depend in large part on international nancial support in order to function. Donors tend to channel their assistance through non-governmental organizations (NGOs) which support what they consider to be priority programs, thereby bypassing and ultimately weakening the national authorities.

1 Sources for this chapter include: Institut Haïtien de statistique et informatique (IHSI 2010); World Bank, Haiti at a glance (2006); WHO, Haiti Health Pro le (2010); United Nations, World population prospects: the 2008 revision (2009).

2 United Nations Stabilization Mission in Haiti.

Health status

Health statistics, although unreliable, show a high level of all communicable diseases, and non-existent access to health care for half the population, particularly the poor and those living in rural areas. Although there is private health care, this is primarily available in the cities and used by the elite. Generally, 75% of health care (of varying quality) is provided by religious and secular NGOs. Most NGOs establish their own priorities and standards, often without taking into account those advocated by the Ministry of Health. is explains why Haiti is often referred to as “a Republic of NGOs”.

Specialized services, such as post-trauma rehabilitation, mental health, and blood banks - critical in the wake of a catastrophe - do not even meet established modern standards, and are insu cient for needs even under normal circumstances.

Delivery of medicines and other essential supplies to the health sector is handled by PROMESS (

The "uniqueness" of Haiti

Haiti is in some ways a unique case, not only within the Americas, but also amongst countries recently a ected by large-scale disasters, such as the Indian Ocean tsunami (Sri Lanka, Indonesia 2004) or the Pakistan earthquake (2005). Table 1 summarizes some of the key di erences. e data suggests that, in terms of development, Haiti is more comparable to Pakistan than to its immediate neighbors or to some of the other countries recently a ected by disasters.

Indicator	Haiti	Dominican Republic	Sri Lanka	Pakistan	Indonesia
Population (millions)					
Gross national product/per capita (2010, US$)[4]					
Life expectancy (years)					
Mortality under 5 years old					
Vaccination against measles (%)					
Doctors per 10,000 inhabitants					

Impact on health

a. Mortality

Estimates of the death toll vary widely, depending on sources. e highest initial estimate provided

d. Nature of injuries

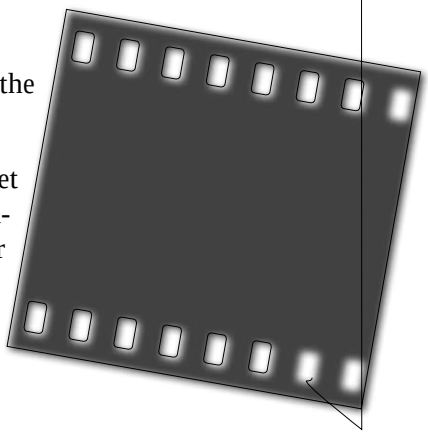
During the rst ten days following the earthquake, few medical teams kept detailed records or even summaries of the types of pathologies encountered. It was only after two weeks that a pro le of types of interventions began to emerge, based on statistics published by certain eld hospitals - although each team used its own system of classi cation (terminology, numerator and denominator) and timeframe.

ese data (see table 3), however disparate, underline the relative frequency of injuries to limbs, head and spinal cord injuries, amputations, and crush syndrome.

Injuries/Interventions	Range
Head or spinal cord	-
Fractures to limbs	
Amputations	-
Crush syndrome	-
Infected wounds	-

e large disparities in the range of gures re ect the diverse nature and role of care providers (ranging from a general medical team at a referral hospital to more sophisticated medical establishments), the mix of diagnoses and types of interventions referred to in reports, and nally, the varying timeframes used.

Certain conclusions can nonetheless be drawn:



- Secondary infections were by far the most common problem encountered once the initial emergency had passed.
- Post-crush renal failure appears less prevalent than in other disasters (Vanholder et al. 2011). It is not clear if this is due to a lack of accurate diagnoses, high mortality caused by insu cient care during the rst week, or if it in fact re ects a lower incidence level?
- More than 100 cases of paraplegia were reported in the initial months after the earthquake.[10] Once again, the number of such victims who did not survive the rst week is unknown (Burns, O'Connell, and Landry 2010).
- Finally, it was only after two weeks that consultations linked to the earthquake began to re ect normal pathologies.

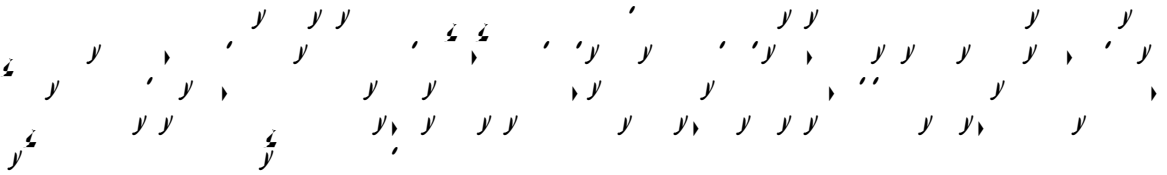
9 Compiled from di erent sources: Magloire et al. (2010); Handicap International (2010); and Calvot and Shivji (2011).
10 Con dential database managed by Healing Hands for Haiti.

e most rapid, and therefore most e ective, response is carried out by national authorities and organizations already on the ground. e subsequent external response to the earthquake in Haiti was massive, and involved a wide variety of actors, some of whom were of questionable competency.

Haitian actors

a. National health personnel

A number of reports have underlined the dedication of national health personnel during the rst days following the disaster, working under much more di cult conditions than those eventually faced by external medi-



e di erence is quantitative: in Banda Aceh (Indonesia), about 180 agencies were registered in all sectors. In Haiti, about 400 agencies were registered in the health sector alone (data from the Center for Coordination in Health/ Cluster).

c. Latin American and Caribbean countries

Practically all countries in the region o ered medical or health assistance. Neighboring countries played a particularly important role in this instance of south-south aid:

- e Dominican Republic mobilized all of its health resources to o er immediate care to thousands of Haitians, many of them seriously injured, owing across its border (WHO/PAHO 2010).
- Cuba, with some 300 health professionals already in place, quickly reinforced these with intervention teams, treating more than 20,000 patients.[11]
- Jamaica, in addition to its medical assistance on behalf of the Caribbean region, provided Haitian health personnel with short rest and recuperation (R&R) breaks in Jamaica.

d. Bilateral aid

e United States, Canada, France (Martinique and Guadeloupe), and many other countries throughout the world demonstrated their solidarity with Haiti. Aid was both governmental and private in nature, and also took the form of institutional support from universities. Health assistance from the United States was of particular note, ranging from the high-tech medical technology of the USNS Comfort naval hospital to clinical and epidemiological support provided by the Centers for Disease Control (CDC) to the Haitian Ministry of Public Health.

Several lessons can be gleaned from the massive intervention by university groups including, amongst others, Harvard, Miami, and Chicago Universities. In short, being part of a world-renowned group of universities is not in itself su cient for an e ective response:

1. Previous experience in the country, or at least close collaboration with a local partner, is essential.
2. Involvement should not be limited to medical matters, but also extend to administrative, nancial, and logistical issues.

11 Information provided to WHO /PAHO by the Cuban medical brigades.

Lessons

In comparison with other recent massive disasters (the Indian Ocean tsunami in 2004 and the Pakistan earthquake in 2005):

- External medical assistance in Haiti fell far short of meeting actual needs, whereas it became quickly super uous following the tsunami.
- e external response was much more rapid (18 hours instead of three to four days), due largely to Haiti's geographic location.
- e lack of logistics support from local military forces (present in the other two cases) was compensated for by the presence of MINUSTAH and the armed forces of large neighboring countries.
- A novel role was played by the "diaspora" of expatriate Haitian doctors, as well as by large US universities.

Nevertheless, other observations only con rm a trend seen in previous disasters: the increased and uncontrolled proliferation of medical agencies leads to the presence of many ill-prepared, and in some cases incompetent, actors. Filtering and coordination mechanisms were simply overwhelmed by this in ux.

a (

A post-disaster health response can be divided into two phases:

1. e immediate response, which focuses on saving as many lives as possible. is phase concentrates on life-saving measures and urgent trauma care.
2.

It has often been noted in previous disasters that foreign teams generally arrive too late, after national services and those of neighboring countries have already responded to the most urgent needs. is was not the case in Haiti, where the demand for trauma and/or orthopedic care by far surpassed the available supply, however generous.

External medical assistance included the deployment of ve naval hospitals (from Colombia, France, Mexico, Spain and the United States).[17] O ering varying levels of technological capacity, these facilities arrived a week after the earthquake and stayed for periods ranging from 10 to 64 days.

Mobile clinics and hospitals collaborated to varying degrees with local authorities, ranging from respect and cooperation on the one hand, to in e ect taking over public facilities and excluding participation by local personnel on the other.

e weakness and marginalization of existing health authorities, as well as a lack of pre-established standards, made it impossible to put a halt to the activities of certain medical teams, seemingly present for purely opportunistic and self-interested reasons, and considered incompetent by the international community. Despite such cases of incompetence and questionable behavior, most foreign teams did contribute to reducing the loss of life and the permanent after-e ects of the disaster.

b. Triage of the injured

e International Society of Nephrology, which specializes in the treatment (including dialysis) of such cases, intervened in collaboration with Médecins sans Frontières.[18] Five days after the earthquake, eight dialysis units were operational. However, they remained under-utilized for a variety of reasons, principally a failure to communicate their availability to other partners during coordination meetings (Health Cluster) (Vanholder et al. 2010).[19]

• Spinal cord injuries

As in cases of renal failure, spinal injuries do not t neatly into normal triage criteria – i.e. treating patients with the greatest chance of survival at least cost in terms of resources.

Nevertheless, more than 150 persons received appropriate care thanks to the e orts and services of groups dedicated to this type of treatment and rehabilitation. ese groups included NGOs specialized in rehabilitation, as well as the naval hospital.

According to key informants, the probability of survival and rehabilitation in these cases was far greater than that of accident victims prior to the earthquake.

• Amputations

A preliminary report by Handicap International three weeks after the earthquake projected a very high number of amputations. Initial estimates of 2,000 to 4,000 amputations were subsequently revised downward to between 1,200 and 1,500 (O'Connell, Shivji, and Calvot 2010). e percentage of amputations in relation to other interventions varied widely between the various medical teams.

e use of a rapid intervention technique known as the 'guillotine' makes it di cult to t a prosthesis, and patients undergoing this treatment subsequently needed a series of corrective interventions on the stump. e physical extent of the amputation is equally important. Of 107 cases reviewed by Handicap International, 43% involved amputations above the knee (O'Connell, Shavji, and Calvot 2010).

Based on available information, it is however not possible to conclude that a signi cant number of amputations were unnecessary, especially considering the extraordinarily precarious conditions under which interventions took place. It is nonetheless crucial that standards and a monitoring system be put in place during the rst few hours following a disaster.

d. Post-operative care, referrals, and medical evacuations

• Post-operative care

In Haiti, as in many other disaster-a ected countries, medical teams concentrated on emergency surgery, to the detriment of follow-up care. Post-operative care requires a lot of time and patience, as well as su cient nursing personnel - rare commodities in the humanitarian eld.

18 e Renal Disaster Relief Task Force (RDRTF).

19 MSF generally abstains from participating in the inter-agency meetings (clusters).

One exception deserves mention: the Jimani Hospital (Dominican Republic) and a Haiti-based NGO (Love a Child), joined forces with WHO/PAHO to convert a school into a post-operative care center in Haiti, capable of handling 400 injured persons.

Taking into account the large proportion of secondary infections, it is critical that more attention be directed to this problem, and to increasing the proportion of nursing personnel among humanitarian personnel.

• Referral between care facilities

Transfer of patients between care facilities was one of the most di cult problems to solve - in large part due to a lack of specialized services to treat patients, but above all because of a severe lack of information and communication between the di erent teams and hospitals, each one overworked and operating independently ("bubbles of excellence").

Examples of the impact of such poor information-sharing and communication include the under-utilization of the center for dialysis, and the existence of cases of persons with spinal cord injuries being left on mattresses by the roadside due to a lack of awareness of the existence of organizations capable of treating them.

It was not until four weeks after the disaster that those responsible for health coordination (the Health Cluster) circulated a list of specialized services, with telephone numbers.

• Foreign medical evacuations

In Haiti, as opposed to Indonesia, Sri Lanka, and Pakistan, there was no possibility of evacuating more complicated cases to other provinces or departments.[20] All in-country specialized medical facilities were in fact located in the very capital city that had been devastated by the earthquake.

e only alternative was therefore to treat people where they were, or to evacuate them out of the country (to the United States, French territories in the Caribbean, etc.).

An indeterminate number of patients were evacuated to host countries during the rst few days following the earthquake. However, a number of obstacles subsequently led to a drastic reduction in the frequency of such evacuations. ese included immigration issues, ethical (and economic) dilemmas - particularly regarding long-term treatment (i.e. the lack of services in Haiti to ensure follow-up to

Communicable diseases

Even though epidemics are rare after this type of disaster, the rapid establishment of a basic surveillance system for communicable diseases is generally considered a priority (Watson, Gayer, and Connolly 2007). In Haiti, the magnitude of the impact, coupled with the large number of public health providers, slowed this process. It was not until 12 days after the earthquake that partners agreed on a document listing 25 conditions to be reported on by 51 sentinel sites, selected from among the 94 preexisting health facilities a liated with the program to combat HIV/AIDS.[21]

e system had a number of shortcomings:

- A very late start ;[22]
- A list of conditions to report on that was too complicated and too large, trying to re ect the di erent priorities of the numerous partners;
- e lack of inclusion of foreign medical teams and facilities (including hospitals) in the surveillance system.

From 25 January to 24 April 2010, no unusual epidemic was detected. e pathology reported corresponded to the normal pro le for a country such as Haiti (i.e. respiratory infections, malaria, and fevers) (Magloire et al. 2010).

Among the positive points, it is worth mentioning the e ective strengthening of the Haiti National Public Health Laboratory, thanks to support from the CDC, as well as reinforcing routine immunization programs.

In fact, the Ministry of Health wisely decided not to encourage indiscriminate vaccination campaigns, as often happens following massive disasters subject to widespread media coverage. Priorities were directed selectively towards:

- e prevention of post-traumatic tetanus, the number of cases of which remains subject to speculation. It is surprising to note that certain external medical teams did not have anti-tetanus vaccines;
- Proceeding with a planned diphtheria, pertussis and tetanus (DTP) vaccination campaign to contain a prior diphtheria outbreak;
- Strengthening the (very weak) coverage of vaccination of measles, mumps and rubella in the temporary settlements. is directive was ignored by some large humanitarian NGOs that decided to apply their own strategies and criteria.

Mental health and psychosocial assistance

ese two terms are often used interchangeably. Before the disaster, mental health care for clinically severe cases was limited to institutionalization in one of two psychiatric facilities. Health centers and hospitals were not in a position to o er specialized assistance (WHO 2010a).

21 US President's Emergency Plan for AIDS Relief (PEPFAR).

22 e Dominican Republic authorities established a system of epidemiological surveillance within the rst three days.

In previous disasters, there has been a certain obsession with post-traumatic stress syndrome and the 'medicalization' of its treatment. As has been noted in WHO directives, mental health and psychosocial assistance during emergencies covers more than just this syndrome. In Haiti, WHO/PAHO estimated that, at one point, more than 110 organizations or groups claimed to o er specialized assistance in this area.[23] is ranged from recreational activities for children, to highly sophisticated psychiatric expertise.

Although the actual impact of psychosocial assistance on bene ciaries cannot be measured, its impact on Ministry of Health policies and sta attitudes has clearly been positive. Mental health has become a priority in primary health care. An opportunity for change has been seized.

Supplies

Following the earthquake, the principal concern was re-launching the commercial and subsidized distribution systems, and putting in place reservoir systems in line with the levels of population displacement across the city, rather than repairing water pipes.

One of the encouraging developments was the leadership exercised by the National

Many studies clearly show that the rate of clinical malnutrition did not increase in Haiti. at is not surprising, given the enormous quantities of food distributed, as well as generous transfers of funds by members of the Haitian “diaspora”.

I a a

e information required to guide an e ective response is not limited to the number of deaths (a gure of no operational value), the number of injured (impossible to measure until there is no longer a need for it), or a census of displaced persons (a useful but constantly changing gure). Information needs are varied, speci c, and potentially unlimited. e di culty is to di erentiate between what one wants to know and what one needs to know.

The initial rapid assessment

An initial assessment, involving most actors, aims to identify essential needs that cannot be addressed through available local resources. Speed is more important than comprehensiveness or a high degree of accuracy. e critical objective is to guide and direct external assistance, not to produce a report or provide data for mobilization of resources several months later. International assistance, however, has its own dynamic and logic (too often political). It is mobilized immediately and without waiting - as shown in a study after the Indian Ocean tsunami of 2004 - and subsequently, without truly taking into account the results of an inter-agency evaluation (de Ville de Goyet and Morinière 2006).

e initial rapid assessment in Haiti was undertaken by the international community eleven days after the earthquake. e results were not shared with partners until more than a month later. e shortcomings of this initial assessment, which cost more than US$3 million, were many:

- A questionnaire not adapted to the linguistic and cultural context of Haiti;
- A list of indicators that was too long (interviews lasted three hours) and that was of little relevance to immediate operational needs. is was the outcome of a consensual approach, which allowed each interviewer to cover topics of institutional interest in an exhaustive manner ;
- A nal report that included hundreds of tables and graphics relating to “needs” without distinguishing between chronic problems linked to poverty, and those caused by the earthquake.

Impact analysis

e Post-Disaster Needs Assessment (PDNA) is a multi-sector exercise under the responsibility of the government. e objective is to determine the physical impact, economic losses (direct and/or indirect), and human and societal consequences of a disaster. e PDNA does not guide the rescue operations, but rather the rehabilitation and recovery processes.

As is often the case, this focused primarily on infrastructure, even though many of the challenges were in fact to do with governance and institution-building. In the health sector, the PDNA allowed for a collective review of innovative ideas for reform, many of which were at the pilot project phase prior to the earthquake.

Specific assessments

In Haiti, as in other countries a ected by sudden-onset disasters, there was a proliferation of studies and assessments designed to produce information speci cally focused on a particular discipline or on certain groups of bene ciaries. Results were generally more relevant to the agency responsible for carrying out the study.

e challenge was to integrate such speci c data into a more holistic view, accessible to all. e conclusions of some of these studies were disseminated, whilst others remained con dential. A positive development was the creation of working groups, established by OCHA at inter-sectoral level and by the Ministry of Health at sectoral level, in order to compile all available information (i.e. an inventory of studies).

Information on in-coming aid

e emergency was met with an uninterrupted ow of personnel and supplies. E orts to inventory the ow and, if possible, adjust supply to demand were not even remotely successful. However, two initiatives do merit mention:

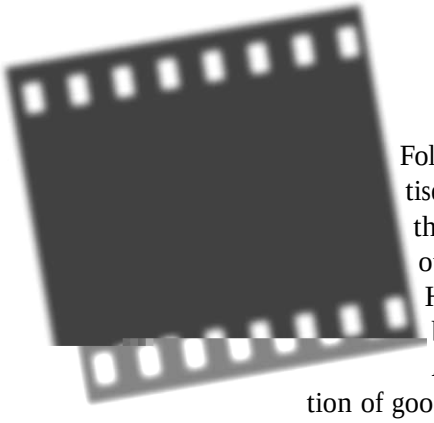
a. Lists and maps of agencies and organizations

A list of actors - the so-called 3W list ("Who is doing What and Where?") - was prepared at inter-sectoral level and for each sector, including health. e value of this information depends on the collaboration and transparency of all those involved. In the health sector, 390 agencies were registered through the coordination mechanism (cluster). is number probably represented less than half of the total. Many volunteer teams did not see the use of registering. e tasks of validating, completing, and regularly updating information would have had to be undertaken by human resources at the expense of other priorities.

e production of detailed maps was a much-appreciated service. e wide variety of maps facilitated the spatial visualization of all types of interventions and health resources. ese geographic information systems, however, could only disseminate the information available in the databases, which was often incomplete and unreliable (based on what actors said they were doing or intended to do).

b. Inventory and registration of donated supplies

Systematic registration of relief goods (regardless of their source or destination) is indispensable to identifying local and overall shortages or surpluses.



Following massive disasters over the past 20 years, WHO/PAHO has o ered expertise of a Logistics Support System (LSS/SUMA). Activated in the rst days after the earthquake, LSS/SUMA regularly provided detailed reports about medical and other supplies arriving in transit through the Dominican Republic or directly to Haiti. In contrast to other information systems, LSS/SUMA was managed directly by Haiti's Directorate for Civil Protection and not by international organizations. Although the information provided by LSS/SUMA was based on physical inspection of goods at ports or airports, its utility also depended on collaboration by agencies and organizations (as with all such initiatives directed towards cataloging external aid). Too many actors were reluctant to share this information, or ignored government directives concerning registration.

c. Contribution of the media and social networks

In all disasters, external assistance is mainly governed by media coverage. It is therefore not surprising that humanitarian actors in Haiti - whose criteria for success is measured by the amount of resources mobilized - view the media as a public relations mechanism or as a vehicle to promote their priorities, rather than as a channel for education and public information.

In Haiti, for the rst time, social media (Twitter, YouTube, Facebook, Skype, etc.) rivaled the monopoly of broadcast communications media (press and television). In the rst 24 hours after the earthquake, numerous images and reports came not through professional media outlets, but from average citizens on-line (MacLeod 2010).

e implication of this trend for future disaster response is not clear. But one thing is certain: the state monopoly of information (with pacy ng comments such as "the situation is under control"), as well as the press monopoly in communicating with the public, will be called in question.

C a

Donors invested signi cant funds in coordination, whilst ensuring that their own bilateral aid was not subject to the very mechanisms they had contributed in creating. Did this nancing e ort bear fruit? If key informants are in agreement on one point, it is the chaotic nature of the external response. A high-level United Nations o cial even went so far as to say that this lack of coordination was ultimately advantageous to bene ciaries, because it allowed a number of small volunteer groups to provide services without hindrance.

e rst question then is, in the context of a natural disaster, who should coordinate: the international community or the a ected country? United Nations documents and their corresponding directives are clear: the national government has this responsibility. In practice, the situation depends on the balance of power. In Haiti, faced with large donors, a plethora of NGOS ("the Republic of NGOs"), and the political presence of an integrated UN mission directly under the aegis of a Special Representative of the Secretary-General, the government simply did not have su cient leverage, compared to that of the international community and the United Nations.

National coordination

In Haiti, humanitarian agencies and donors marginalized, over a prolonged period, those national institutions judged to be "weak and corrupt." Even if one cannot deny the need for provisional international leadership during a disaster that so profoundly a ects national structures, the operative word here is prolonged (i.e., beyond the three months covered by this study).

e operational arm for emergency coordination in Haiti is the Directorate for Civil Protection (DPC), which receives support from the World Bank, the UK's Department for International Development (DFID), and the European Union. Lacking any in uence over human resources and relief goods entering the country, without direct access to information about who was doing what (Presidential directives for entities to register with the competent ministry were ignored by 90% of the actors), and deprived of logistical means (which were in the hands of bi-laterals or the World Food Programme), the DPC could not ful ll its role in directing either the response or the recovery phases.

e President established numerous commissions, one of which dealt with the health sector. Opinions vary regarding the utility of the latter, given the strong tensions that already existed between the bureaucracy and political levels within the Ministry.

International coordination

a. Humanitarian Reform

e Inter-Agency Standing Committee (IASC) was established in 1992, to act as a forum for coordination and decision-making involving external humanitarian actors. Disaster-a ected countries do not participate in meetings of the committee. In 2005, IASC adopted a Humanitarian Reform that introduced, amongst other things, the "Cluster Approach", according to which activities pertaining to a speci c technical area are coordinated by an agency of the United Nations system. e term "cluster" does not coincide with the traditional notion of sector, given that the technical areas covered correspond more to the mandates of the di erent UN agencies within IASC, rather than to the classic structure of the public sector at the national level. e health sector, for example, is divided between three clusters (nutrition, water/sanitation, and health). Psychosocial assistance (mental health), the medical aspects of sexual violence, and care in the camps are likewise coordinated through several clusters. e

e experience of DINEPA is an exception that brightens this otherwise dark picture. As mentioned earlier, this recently-created agency was able to establish its technical leadership in the area of water and sanitation, although not without facing initial reticence on the part of the lead agency for the relevant "cluster." DINEPA emerged strengthened.

Other factors played a role:

- Insurmountable logistical constraints. From day one, some of the experts mobilized lacked transport or the necessary means of communications.
- Constraints to in-country movement, due to UN security concerns and rules. e risk in Haiti was greatly exaggerated, paralyzing not only coordination e orts, but even life-saving operations after sunset.[27]

e task of coordination was itself probably too ambitious, taking into account the large number of actors with varying degrees of capacity and competence, all of them convinced that their mission was indispensable.

Certain lessons, learned too late in the case of Haiti, may be applied to the next disaster:

- e Ministry of Health should assume from the start the (co-) leadership of the Cluster. Real au-

S a - a

a. Re-establish the authority of national health structures

e active participation of the Ministry of Health is an indispensible condition to improving the professional quality and coordination of the health response. Only the Ministry has the necessary authority and mandate; it is also necessary to ensure that it has the means. Strengthening competencies and capacity certainly has its costs, but the "return on investment" will be signi cant.

b. Ensure quality control of medical assistance

Coordination and information management are necessary but elusive objectives. A certain degree of chaos is inevitable, and will always be a part of disaster response. On the other hand, the practice of medicine and the provision of pharmaceuticals are normally amongst the most regulated of a country's activities. In times of disaster, the most basic supervision and quality control are absent, allowing for abuses that would never be tolerated in normal times.

A rst step toward the accreditation of medical actors during humanitarian crises is the formulation of basic technical procedures and standards, and prior registration of those organizations deploying medical teams and eld hospitals. Such a global database, accessible to ministries of health, would facilitate a prioritized deployment of pre-inventoried teams, and enable scrutiny of the quali cations of other potential actors.

c. Improve coordination

e cluster approach should be adapted to the structures of each particular country. To do so, an agreement must be negotiated in advance with national authorities responsible for emergency coordination. Within the framework of this agreement:

1) e government determines the number of clusters and their technical mandate, re ecting its own structures.

2) e government, in consultation with the UN Humanitarian Coordinator, designates the international agency responsible for supporting the relevant ministry in the management and coordination of the sector/cluster at national level. is selection is independent of responsibilities assigned at global level.

3) Following a disaster, the UN Resident Coordinator mobilizes this mechanism, and manages it for an initial period, the length of which depends on the seriousness of the situation.

4) A deadline (e.g. three weeks, re-negotiable?) for the transfer of this responsibility to the government is arranged by common agreement.

a

Relief activities should not hinder development. e ideal is a synergy between relief and reconstruction.

Even the worst disaster can engender positive changes over the long-term. Such was the case in Haiti. Some of the more promising changes are mentioned below:

- Free access to healthcare: Requiring a nancial contribution from patients was a factor that limited access to basic healthcare prior to the earthquake. e earthquake prompted the Ministry of Health to adopt a policy of free care during the emergency period. is more equitable approach seems to be taking hold. e international community has supported a WHO/PAHO initiative for on-going free obstetric and pediatric care.[28]
- A more profound reform of mental health care, as mentioned earlier.
- Social acceptance of the handicapped, and support from the state for post-traumatic physical handicaps.
- An awareness of the signi cance of sexual violence.
- Strengthening the public health laboratory and the surveillance system.
- Strengthening DINEPA, further to its performance, with international support for this institution.
- Greater awareness of nutritional priorities.
- A more accelerated trend towards decentralization of health resources and services to the departmental level.
- Greater awareness of the need to reduce vulnerability to earthquakes and other natural hazards.

C

In conclusion, “lessons learned” have a tendency to identify what did not work. But this exercise should not allow us to forget the remarkable accomplishment of the humanitarian community in Haiti. It saved many lives and responded to the immediate needs of hundreds of thousands of survivors, despite de ciencies noted in the management and governance of the response.

If indeed there were many shortcomings, most are not unique to the response in Haiti. Rather, they are repeated in all cases where massive international assistance is deployed, as has been shown in many previous studies and evaluations. e problem is not primarily caused by a lack of governance in the a ected country, but rather is inherent to a humanitarian community that seems powerless to put “lessons learned” into practice.

28 Free obstetric care (SOG–in French) and free pediatric care (SIG–in French).