



HAITI

“Nobody Remembers Us”

Failure to Protect Women’s and Girls’ Right
to Health and Security in Post Earthquake Haiti

HUMAN
RIGHTS
WATCH



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- Summary 1**
- Key Recommendations.....7**
- Methodology 9**
- I. Background12**
 - Women’s Legal and Political Status in Haiti..... 12
 - Women’s Health and Gender-Based Violence in Haiti Before the Earthquake 14
 - Maternal Health 14
 - Family Planning..... 16
 - Gender-Based Violence (GBV) 17
 - Reforms and Efforts to Reduce Maternal Mortality before the Earthquake 20
 - Women’s Health and the Health System after the Earthquake..... 21
 - Haiti’s Human Rights Obligations.....24
- II. Obstacles to Maternal and Reproductive Health: Failure to Protect Women’s and Girls’ Rights.....27**
 - Lack of Access to Family Planning27
 - Lack of Access to Information 28
 - Access to Contraception and the Right to Decide on the Number and Spacing of Children .30
 - Illegal and Unsafe Abortion as a Response to Lack of Access to Family Planning32
 - Obstacles Accessing Prenatal Care35
 - Lack of Access to Information35
 - Economic Accessibility.....37
 - Obstacles Accessing Obstetric Care 40
 - Lack of Access to Information on When and Where to Access Obstetric Care42
 - Obstacles to Accessing Available Obstetric Care.....43
 - Obstacles to Quality Care at Medical Facilities..... 46
 - Impact of Food Insecurity on Reproductive and Maternal Health 48
 - Food Insecurity for Pregnant and Lactating Mothers 48
 - Food Insecurity and Increased Vulnerability to Unintended and Unwanted Pregnancy50
 - Vulnerability to Gender-Based Violence52
 - Lack of Accountability in Addressing Women’s and Girls’ Health and Security in Displacement Camps.....58

| | |
|--|-----------|
| III. Donor States and Non-State Actors in Haiti | 61 |
| Reproductive and Maternal Health | 62 |
| Gender-Based Violence | 68 |
| IV. Conclusion | 70 |
| V. Recommendations | 72 |
| Acknowledgments | 78 |

Summary

We live in this camp, in the dirt ... and nobody remembers us.

—Charlise, camp in Delmas 33, Haiti, November 2010

The extreme hardships of people living in post-earthquake Haiti are well-known: many who now live in the informal displacement camps that sprung up after the January 12, 2010 disaster go to bed hungry, live in wind-tattered tents that let in rain, face the same high levels of unemployment as other Haitians, and lack adequate access to clean water and sanitation. Many face eviction by both public and private actors, and children—sick from the bad living conditions and often not in school—live without basic levels of security.

But women and girls in post-earthquake Haiti face additional hardships: lack of access to family planning, prenatal and obstetric care; a need to engage in survival sex to buy food for themselves and their children; and sexual violence. The crisis is reflected in pregnancy rates in displaced person camps that are three times higher than in urban areas before the earthquake, and rates of maternal mortality that rank among the world's worst.

The situation is not entirely new: women and girls in Haiti died during pregnancy and childbirth at alarmingly high rates even before the earthquake. They also faced high levels of domestic and sexual violence, crushing poverty, and a stark disparity in access to education compared to men. However, the earthquake has exacerbated the vulnerabilities of this already vulnerable group.

Based on research conducted in Port-au-Prince in late 2010 and early 2011—and interviews with 128 women and girls living in 15 displacement camps in 7 of the 12 earthquake-affected communes—this report looks at women's and girls' access to reproductive and maternal care in post-earthquake Haiti. It examines the impact that food insecurity has on reproductive and maternal health; the reliance on transactional sex that some women and girls have developed in order to survive; and their vulnerability to, and the consequences of, gender-based violence (GBV). It also considers Haiti's human rights obligations, and the need for mutual accountability between the government and donor states and non-state actors in the country.

The report finds, 18 months after the earthquake, the voices of women affected by the earthquake have been excluded from the reconstruction process—even though women are integral to the country's economy. Moreover, initial optimism felt by international aid

agencies and donors that access to maternal health would improve in areas affected by the disaster has not been realized for all women and girls. This is despite an outpouring of international support and of new, free services run by international nongovernmental organizations (NGOs) that promised to remove the geographic and economic barriers that had historically prevented women and girls from accessing health care.

For the women and girls interviewed by Human Rights Watch in the camps, their enjoyment human rights, such as the rights to life and health, remains poor (notwithstanding benefits accruing from the presence of free care and experts on the ground), and most of them lack basic information that would allow them to access available services. Indeed, as is widely recognized, Human Rights Watch found evidence of three types of delay that contribute to pregnancy-related mortality: delay in deciding to seek appropriate medical care; delay in reaching an obstetric facility; and delay in receiving adequate care when reaching a facility. For the women and girls we interviewed, these delays occurred because women and girls did not recognize signs of early labor or were unfamiliar with a new neighborhood; because the places where they previously received care had been destroyed in the earthquake; because of distance, security concerns, or transportation costs; and because of inadequate care at facilities.

Most women and girls interviewed by Human Rights Watch did not know which organizations worked in and around their camps, when and where services were available, and to whom they should complain if there was a problem. They also face serious obstacles accessing or learning about prenatal and obstetric care and family planning—impeding their ability to control the number and spacing of their children, and compelling some to have illegal and unsafe abortions that threaten their health and safety. Barriers accessing services are particularly worrying when it comes to adolescent girls, who may face additional risks in their pregnancy due to their age. Though prenatal care is often free, poor women and girls sometimes cannot pay for transportation to go to appointments and may stop seeking care if they cannot afford prescriptions for necessary tests, such as a sonogram. Some women and girls we interviewed remain at home for delivery because they think (wrongly) they cannot return to the hospital without the sonogram. The women and girls interviewed by Human Rights Watch also experienced difficulties accessing care when delivering. Although most said they wanted to deliver in a hospital, over half of those who had given birth since the earthquake had done so somewhere other than a medical facility and without a skilled birth attendant: a significant number delivered in a camp tent or on the street en route to hospital. “I just gave birth on the ground,” said Mona, who lives in a camp in Delmas 33. “I had no drugs for pain during delivery.” She finally saw a doctor three days later: he gave her three tablets for pain relief.

Another problem is food insecurity in the camps, which leaves some pregnant women and girls, and lactating mothers interviewed by Human Rights Watch and their children without proper nutrition: one woman, Adeline, was forced to feed her three-month-old cornstarch mixed with water because she lacked sufficient breast milk for her child. Other women and girls said they felt weak due to insufficient food.

The extreme vulnerability and poverty in the camps—general food distribution stopped within two months of the earthquake and unemployment in the camps is very high—has led some women and girls interviewed by Human Rights Watch to form relationships with men for the sake of economic security, or to engage in transactional or survival sex. According to the women and girls we interviewed and recent surveys conducted by other human rights organizations, the exchange of sex for food is common. “You have to eat,” Gheslaine, who lives in a camp in Croix-de-Bouquets, said simply. Without adequate access to contraception, women and girls face increased vulnerability when they survive by trading sex for food. Moreover, many engage in these practices in secret, making them vulnerable to violence because they lack what little protection may be available to them from social networks or the community.

Women and girls in Haiti also face gender-based violence, a problem even before the earthquake. Human Rights Watch found that some survivors of sexual violence in the displacement camps had difficulty accessing post-rape care necessary to prevent pregnancy or transmission of sexually transmitted disease. Social stigma and shame can create further obstacles to seeking care. Six of the pregnant women and girls who spoke with Human Rights Watch—3 of whom were 14 to 15 years old—said their pregnancies resulted from rape. These numbers may be higher than those documented here since we undertook interviews to discuss access to health services, rather than violence in particular. The women and girls who reported rape to Human Rights Watch did so in the course of an interview about maternal and reproductive care. Women and girls pregnant from rape face the same obstacles in accessing reproductive and maternal care as others, with the added stigma and trauma of being a rape victim.

Many NGOs, donors, and experts on maternal health have sought to address the needs of women and girls in post-earthquake Haiti. Most notably, the Free Obstetric Care project (Soins Obstétricaux Gratuits, SOG), which started in 2008, continued operating after the earthquake to give women and girls free prenatal care and has succeeded in providing access to care that was previously unaffordable. Yet a significant number of women and girls interviewed by Human Rights Watch still do not gain access to clinics or hospitals, give birth without assistance on muddy tent floors, in camps streets and alleys, and—desperate

and hungry—trade sex for food to survive. We found that sexual violence and the lack of post-rape care have left women and girls as young as 14 with unwanted pregnancies.

The government, which should be exercising oversight in the provision of maternal health care, does not have current and comprehensive maternal health data for women and girls living in camps who do not reach one of its facilities for care. Nor does it have data on women and girls who discontinue care. Without that information, it is not possible to identify and implement measures to develop redress mechanisms for mistakes or grievances, to correct systemic failures, or to replicate effective programs.

Human Rights Watch found that important information that is necessary for the Haitian government to monitor progress related to maternal health is not recorded in camps: for example, none of the five infant deaths recounted by women and girls interviewed by Human Rights Watch were reported or registered with any NGO or government body. Camp residents told Human Rights Watch that deaths in the camp, regardless of cause, generally went unregistered. Thus, if women and girls die of maternal-related deaths in the camps, they would not be recorded. This basic data on maternal and infant deaths is fundamental to determining whether the government is making progress on its obligations related to the right to health.

The Haitian government is the primary guarantor of human rights in Haiti, and it retains its obligations to respect, protect, and fulfill the human rights of those in Haiti—even after an earthquake, and despite the fact that the measures it can take are limited in resources and capacity. It is obligated to take necessary measures to prevent sexual violence and maternal mortality and morbidity; to help women and girls prevent unwanted pregnancy; and to address the needs of the more than 300,000 women and girls still languishing in displaced person camps.

The government should ensure women and girls have access to health-related information and advice, including regarding family planning, the means to decide the number and spacing of children, and prenatal, obstetric, and postnatal care. It has a special duty to ensure that adolescents can access adequate information and services appropriate to their particular needs, and to ensure that all women and girls have equal access to family planning and maternal care services. This may require that it make extra efforts to provide women and girls displaced by the earthquake with information on access to available care, and to design specific interventions to improve access to services for vulnerable women and girls engaged in informal transactional sex. As it did with the cholera prevention

informational campaigns, the government may require assistance by NGOs and donors to disseminate this information.

The Haitian government also has treaty obligations to ensure appropriate prenatal care for mothers. It should ensure women and girls have access to skilled birth attendants and, when necessary, emergency obstetric care. Health facilities, goods, and services should be of good quality and physically accessible and affordable, without discrimination. Even when care is free, the government may need to take steps to ensure it is economically feasible for the most vulnerable women and girls to reach the free care.

Moreover, the Haitian government has an obligation under international law to prevent third parties from jeopardizing the sexual and reproductive health of others through sexual violence. Should violence occur, it is obligated to investigate and sanction perpetrators, and should ensure that survivors have access to post-rape medical care.

While the evidence that Human Rights Watch has collected for this report suggests the government is not fulfilling its obligations, the political and economic realities facing the country means that it would be unrealistic to demand that it alone address the obstacles to fulfilling these rights.

Despite significant destruction of government infrastructure and breakdown of the civil service, Haiti published a post-disaster needs assessment and a plan for recovery less than two months after the quake. The plan included efforts to address both maternal and reproductive health and to prevent gender-based violence. Yet, without enough funds of its own, the government is dependent upon donors, international organizations, and several thousand NGOs to fund and implement its plan and deliver a wide range of social services.

Shortly after the earthquake, the Ministry of Health set up its own NGO registry with reporting guidelines for medical NGOs working in Haiti. The Haitian government does not have the capacity to go systematically into the field to check that NGOs provide the services they claim to be, to see if there are gaps in services, or assess if NGOs are duplicating their efforts. Nor does it know if there is an impact on the fulfillment of rights from all of the aid. As a result, it must rely on NGOs to provide it with information about their activities in order to assess what progress has been made towards its recovery plan or the realization of rights. Lack of consistent flows of information and complete data means that it is difficult for human rights monitors and the state to monitor the health plan's implementation and its impact on the realization of rights.

In the 2005 Paris Declaration on Aid Effectiveness, supplemented by the 2008 Accra Agenda for Action, donor and recipient countries have recognized that mutual accountability when it comes to the effectiveness and use of aid, and the ability to monitor progress, is a shared interest. To this end, recipient countries and donors should “establish mutually agreed frameworks that provide reliable assessments of performance, transparency and accountability of country systems.”

The Haitian government and donors (and donor-funded NGOs) should support mutual and strengthened accountability related to recovery and reconstruction aid, which is necessary for rights-holders to make the government accountable for its human rights obligations. The United Nations Office of the Special Envoy does monitor the disbursement of donor pledges to Haiti. In addition to information about when aid money is disbursed, however, donors should provide sufficient information regarding which projects and organizations receive the disbursement, and must coordinate with the government and implementing agencies to set benchmarks regarding progress that funded projects have made.

Donors should also supply data that allows the government and civil society to better monitor outcomes of their aid. The government and donors should improve the way they coordinate and share information related to internal or independent oversight and monitoring and reporting of project outcomes. Together, these steps should provide the government with tools needed to work towards fulfilling the rights of its citizens and be accountable to them, and help ensure that individuals have current and reliable information related to their rights.

Reproductive and maternal health is not ancillary to the larger reconstruction progress. Rather, for women and girls, the fulfillment of their rights—including the right to exercise control over the number and spacing of children, and to safer motherhood, and to live free of violence— is fundamental to any effort to rebuild their lives after the devastation and disruption caused by the earthquake. This is true for all women and girls in Haiti, and not only those living in the camps who are the focus of this report. As Haiti slowly struggles to move forward with reconstruction and relocate those displaced by the earthquake into safe housing, it is important that lack of access to reproductive and maternal care, and gender-based violence, does not exacerbate women’s and girls’ economic and health vulnerabilities.

Key Recommendations

To the Government of Haiti

- Develop and communicate a gender policy consistent across all ministries and government policies. The policy should require:
 - A focus on the rights of women and girls, including their rights to reproductive and maternal health;
 - That all data be disaggregated by gender;
 - The inclusion of gender-specific analysis in program and policy design, implementation, and monitoring;
 - Establishment of concrete gender-specific benchmarks and indicators;
 - Clear avenues for women's and girls' participation.
- Design programs to increase women's and girls' access to information on maternal and reproductive care, availability of post-rape care, availability of medical services, and general information about the reconstruction effort.
- Identify and implement measures that can be put in place to ensure adequate oversight, monitoring, and reporting of programs to allow accountability between rights-holders and the state, as well as between the state and donors. This is essential to assess whether responses on the ground are effectively meeting human rights obligations and if not, what remedial action should be taken to fulfill those obligations.

To the Donor States and Agencies, Multilaterals, United Nations Agencies and International Non-Governmental Organizations

- Develop and communicate a gender policy consistent across the organization or agency. The policy should require:
 - A focus on the rights of women and girls, including their rights to reproductive and maternal health;
 - That all data be disaggregated by gender and be shared with relevant actors, including government entities;
 - Inclusion of gender-specific analysis in program and policy design, implementation, and monitoring;
 - Establishment of concrete gender-specific benchmarks and indicators;
 - Clear avenues for women's and girls' participation.
- Design and fund programs to increase women's and girls' access to information on maternal and reproductive care, availability of post-rape care, availability of medical services, and general information about the reconstruction effort.

- Ensure adequate oversight, monitoring, and reporting of programs to allow accountability between donors (and implementing NGOs) and the government of Haiti.

To the Interim Haiti Reconstruction Commission

- Develop and communicate a gender policy consistent across the commission and its policies. The policy should require:
 - A focus on the rights of women's and girls, including their rights to reproductive and maternal health;
 - That all data be disaggregated by gender and be shared with other actors, including government ministries;
 - Inclusion of gender-specific analysis in program and policy design, implementation, and monitoring;
 - Establishment of concrete gender-specific benchmarks and indicators;
 - Clear avenues for women's and girls' participation.
- Ensure adequate oversight, monitoring, and reporting of commission-approved programs.

Methodology

This report is based on research conducted by two Human Rights Watch researchers in the metropolitan area of Port-au-Prince in November 2010 and January, February, and June 2011.¹

Human Rights Watch interviewed 128 women and girls living in displacement settlements who were pregnant or had given birth since the January 12, 2010 earthquake. Human Rights Watch also conducted 16 female-only group interviews and 11 mixed-gendered group interviews. Human Rights Watch interviewed women from 15 camps ranging in size from 100 to 60,000 people in 7 of the 12 communes affected by the earthquake, including: Carrefour, Cité Soleil, Delmas, Pétion-Ville, Port-au-Prince, Croix-des-Bouquets, and Petit-Goâve.

Human Rights Watch interviewed 61 representatives from NGOs working on health, women's health, women's rights, and gender-based violence. We also interviewed 24 representatives from United Nations Stabilization Mission in Haiti (MINUSTAH) Human Rights section/ Office of the High Commissioner for Human Rights (OHCHR); MINUSTAH Gender section; UN WOMEN (the United Nations entity for gender equality and the empowerment of women, formerly UNIFEM); United Nations Population Fund (UNFPA); United Nations Children's Fund (UNICEF); the office of the United Nations High Commissioner for Refugees (UNHCR); Office of the United Nations Special Envoy to Haiti; Office for the Coordination of Humanitarian Affairs (OCHA); the sub-clusters on Gender-Based Violence and on Reproductive Health; and the cluster on Nutrition.

In most instances, these interviews were conducted in person. In a small number of cases they were conducted telephonically. Human Rights Watch also interviewed the coordinator of Haiti's National Commission to Reconstruct the Health System and six representatives from three state hospitals, all affiliated with the Ministry of Public Health and Population. Human Rights Watch requested interviews with the Ministry of the Condition of Women and Women's Rights, including through contacts with the gender focal point of the Office of the UN Special Envoy, but had not yet secured an interview at the time of writing.

Interviews were conducted in Haitian Kreyòl with the assistance of an interpreter, where necessary. Female interviewers and, when possible, female interpreters conducted all interviews. Researchers attempted to create private spaces within individual tents or elsewhere in the camp environment for interviews. Most interviews were conducted

¹ Two interviews took place in Petite Goave.

individually, except in a few instances where interviewees preferred to speak in small groups.

Human Rights Watch used a multi-step sample strategy. First, camps were selected to ensure representation of a range of types (including: managed, unmanaged, small, large, easily accessible to main roads, and those less accessible). Additional criteria for camp selection included safety and the availability of interlocutors to provide an introduction to camp residents.

Second, women and girls who met the inclusion criteria of being currently pregnant or having given birth since the earthquake were identified in each camp either through interlocutors in the camp or by visiting individual households (tents) and asking whether women and girls who met the criteria were available to speak.

A total of 128 women and girls in 15 camps were initially identified by Human Rights Watch. After initial interviews, 103 (92 women and 11 girls) were found to meet inclusion criteria. The most common disqualifier was giving birth prior to the earthquake. The interviews in these cases were continued to provide background information on camp conditions, access to family planning, women's access to livelihoods, security, and health.

Of the 103 women and girls meeting inclusion criteria, 28 were currently pregnant and 75 had given birth since the earthquake. Eleven of the interviewees were girls ages 14-17, and three were 18-year-olds whose pregnancies began when they were 17.

All participants provided oral informed consent to participate and were assured anonymity. As a result, pseudonyms or first names only have been used for each individual interviewed. Individuals were assured that they could end the interview at any time or decline to answer any questions, without any negative consequences. All participants were informed of the purpose of the interview, its voluntary nature, and the ways data would be collected and used.

No interviewee received compensation for providing information. Four women and girls interviewed by Human Rights Watch asked to be interviewed outside the camp for added security and received compensation for expenses they incurred while traveling to the interviews. Where appropriate, Human Rights Watch provided contact information for organizations offering legal, counseling, or social services.

In this report, the word “child” refers to anyone under the age of 18, with “girl” referring to a female child. The Convention on the Rights of the Child states, “For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.”²

² Convention on the Rights of the Child, G.A. res. 44/25, U.N. Doc. A/44/49, entered into force September 2 1990, ratified by Haiti June 8, 1995, art. 1.

I. Background

Pregnancy is not a disease, yet globally, hundreds of thousands of preventable maternal deaths occur every year.³ In Haiti, almost 3,000 women and girls die each year due to complications related to pregnancy and childbirth.⁴

Haiti was struggling to reduce one of the highest maternal mortality rates outside of sub-Saharan Africa when the January 2010 earthquake wrought unprecedented damage on its capital and surrounding areas. For women and girls giving birth in the minutes, weeks, months and now years after the earthquake, the risks associated with pregnancy remain, with the added challenges created by the post-earthquake destruction.

The earthquake put additional strain on a population already suffering from chronic poverty and extreme vulnerability to disease, environmental disasters, and political insecurity. Indeed, many women and girls already suffered from a myriad of societal and economic vulnerabilities. The United States Agency for International Development (USAID) found that, prior to the earthquake, “the most fundamental determinants of poor health status in Haitian women ... [were] extreme poverty, poor governance, societal collapse, infrastructural insufficiency, and food insecurity.”⁵ In concert, these factors “undermine[d] the ability of the Haitian state to efficiently and effectively manage its scarce resources to improve access to and the quality of health services...”⁶

In the displacement settlements that Human Rights Watch visited these factors remain obstacles for women and girls seeking access to health services and improved health status.

Women’s Legal and Political Status in Haiti

The precarious status of women may partially explain Haiti’s high rate of preventable maternal death. The Inter-American Commission on Human Rights (IACHR) has consistently stated that “the phenomenon of discrimination against women in Haiti [is] widespread and

³ WHO et al., *Trends in maternal mortality: 1990 to 2008: Estimates developed by WHO, UNICEF, UNFPA and The World Bank* (Geneva: WHO Press, 2010), p. 1.

⁴ Michel Cayemittes et al, *Enquête Mortalité et Utilisation Des Services Emmus-IV Haiti 2005-2006* (Calverton, Maryland, USA: Ministère de la Santé Publique et de la Population, Institut Haïtien de l’Enfance et Macro International Inc., 2007), p. xxix.

⁵ USAID & Management Sciences for Health, “Haiti Maternal and Child Health and Family Planning Portfolio Review and Assessment,” 2008, p. 6.

⁶ *Ibid.*, p. 6.

tolerated, and [is] based on stereotypical perceptions of women’s inferiority and subordination that maintain deep cultural roots.”⁷ The IACHR concludes that this situation, “along with the civil, political, economic, and social consequences of those disadvantages,” make women and girls vulnerable to a range of abuses in both public and private spheres.⁸

According to USAID, women in Haiti “continue to be second-class citizens with unequal representation before the law and state.”⁹ Rape was only criminalized in the penal code in 2005, and marital rape is still not recognized as a crime.¹⁰ The law does not classify domestic violence against adults as a crime; rather, such acts may be punishable “under general laws against assault and battery, depending on the circumstances of the attack and the degree of injury to the victim.”¹¹ The law does prohibit domestic violence against minors. There is no law that prohibits sexual harassment in the workplace.¹² Women in common-law marriages have no legally recognized rights in the union.¹³

Prior to the 2010 elections, only 6 of the 129 legislators in the Senate and Chamber of Deputies were women and there were only 3 women in a cabinet of 18 ministers, despite the fact women and girls comprise over 50 percent of the population. No woman served on the *Cour de Cassation* (Supreme Court). Women’s political participation continued to lag behind in the latest elections, even though a woman, Mirlande Manigat, was a leading presidential candidate.

The electoral code provides incentives for the inclusion of women: it mandates that political parties that nominate at least 30 percent of female candidates and elect 20 percent of those nominated will receive double the amount of public financing for the same positions in the next elections. Not one of the more than twenty political parties met these criteria in the November 2010 elections.¹⁴

⁷ See generally, IACHR, “The Right of Women in Haiti to be Free from Violence and Discrimination, March 10, 2009; and IACHR,” Annual Report of the Inter-American Commission on Human Rights 2010, OEA/Ser.L/V/II., March 7, 2011, p. 593, para. 25.

⁸ IACHR, Annual Report, p. 593, para. 25

⁹ USAID, “Gender Assessment: USAID/ Haiti,” June 2006, p. 8

¹⁰ *Ibid.*, p. 8.

¹¹ UN Commission on Human Rights, Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences, Radhika Coomaraswamy, submitted in accordance with Commission on Human Rights resolution 1997/44. Addendum: Report on the mission to Haiti, January 27, 2000, E/CN.4/2000/68/Add.3, <http://www.unhcr.org/refworld/docid/3boof42ec.html> (accessed 23 May 2011), p. 10.

¹² US Department of State, Bureau of Democracy, Human Rights, and Labor, “Country Reports on Human Rights Practices – 2011: Haiti,” 2011, p. 20.

¹³ USAID, Gender Assessment: Haiti, p. 8.

¹⁴ US Department of State, Country Reports on Human Rights Practices, 2011, Haiti, p. 16.

Women’s Health and Gender-Based Violence in Haiti Before the Earthquake

Haiti’s health infrastructure was in disrepair before the earthquake. The public health system was plagued by lack of coverage, inequality in provision of services, poor finances and inefficiencies, poor decentralization and organizational dysfunction, and “a human resource deficit and weak productivity.”¹⁵ The precarious state of the health infrastructure and high levels of gender inequality resulted in poor health indicators for Haitian women and girls, including those related to maternal and reproductive care.

Maternal Health

Haiti has the highest maternal mortality rate in the Western hemisphere, and lags far behind the rest of Latin America and the Caribbean. Its maternal mortality ratio was 630 deaths per 100,000 live births in 2005-06, up from 523 deaths per 100,000 between 1993 and 2000.¹⁶ Health professionals attributed this sharp increase in maternal mortality to the continued practice of home deliveries and instability in the country, which left women and girls without adequate delivery and postnatal care.¹⁷ Haiti has failed to keep up with the improvements attained in the other countries in the region.¹⁸

Before the earthquake, obstacles preventing women and girls from accessing maternal care included: lack of services or services that were uneven, inadequate, and funded only in the short-term; difficult or delayed access to services; and fear of sexual violence, which prevented them from leaving home to seek care.¹⁹ A 2009 report showed that the prevalence of home deliveries increases during crises in Haiti and the “fear of rape often inhibits women and girls from seeking the care they need, including safer deliveries by a trained healthcare worker.”²⁰ Further evidence shows that women and girls still “face[d] significant risk due to poor quality of service and insufficient availability of equipment and supplies” even when delivering in health facilities and emergency obstetrical centers, while neonatal care remained largely unavailable.²¹ “Every day is a crisis,” one public

¹⁵ Minister of Public Health and Population (MSPP), “Plan Interimaire du Secteur Santé: Avril 2010-Septembre 2011,” March 2010, pp. 2-3.

¹⁶ Emmus-IV Haiti 2005-2006, p. xxix.

¹⁷ Haiti Maternal and Child Health and Family Planning Portfolio Review and Assessment, p. 5.

¹⁸ *Ibid.*, p. 11.

¹⁹ See JSI Research & Training Institute, Inc., “The Long Wait: Reproductive Health Care in Haiti,” 2009, pp. 11-12.

²⁰ *Ibid.*, p. 12. See also, Doctors Without Borders, “MSF Briefing Paper: A Perilous Journey: The Obstacles to Safe Delivery for Vulnerable Women in Port-au-Prince,” May 2008, p. 13, stating that “[m]any women living in the slum communities claimed that they are stuck at home at night during labour due to insecurity and fear of being attacked in the streets even though they want to go to a hospital to see a doctor.” The MSF paper also reported that there are very few admissions to its maternity ward between the hours of 10pm and 6am.

²¹ Haiti Maternal and Child Health and Family Planning Portfolio Review and Assessment, p. 7.

health professional said in 2008.²² Before the earthquake, the health system in Haiti, under the auspices of the Ministry of Public Health and Population (MSPP), struggled to implement even the Minimal Initial Service Package (MISP) for Reproductive Health in Crisis Situation.²³

Some improvements have been made to increase the number of women and girls receiving prenatal care. In 2005-06, 85 percent of women and girls benefitted from some access to prenatal care, compared to 68 percent a little over a decade before.²⁴ Nevertheless, only half of pregnant women and girls have the 4 prenatal visits that the World Health Organization (WHO) recommends.²⁵

But improvements in access to prenatal care have not equally benefitted all women and girls in Haiti, where physical accessibility of health facilities is a strong predictor of their use.²⁶ Women and girls living in rural communities and outside the Port-au-Prince metropolitan area are less likely to have access to antenatal care. Despite this, before the earthquake, some progress had been made in increasing the number of women and girls in rural areas who received care.²⁷

Increased access to prenatal care did not necessarily translate into increased numbers of women and girls delivering in facilities. In 2005-06, less than 25 percent of births took place in a health facility.²⁸ Overwhelmingly, these births were to women with greater incomes. Just over 78 percent of births attended by medical professionals were to women in the top economic quintile, while only 5.9 percent were to women from the poorest

²² The Long Wait: Reproductive Health Care in Haiti, p. 11.

²³ Ibid., citing Sphere Humanitarian Charter and Minimum Standards in Disaster Response. The MISP in Reproductive Health are part of the standards contained in the Sphere Project's Humanitarian Charter and Minimum Standards in Disaster Response. The MISP includes: the prevention of sexual violence and provision of post-rape care; protection against HIV transmission; emergency care for pregnant women and newborns; provision of contraceptives, antiretrovirals and care for sexually transmitted infections (STIs). While family planning is not a component of the MISP in the emergency phase of a crisis, it is an essential component of comprehensive reproductive health services that should be established when the emergency phase has stabilized. See, Sphere Project, *Humanitarian Charter and Minimum Standards in Humanitarian Response, 2011 edition* (Rugby, UK: Practical Action Publishing, 2011), pp. 325-330; see also Inter-agency Working Group on Reproductive Health in Crises, "Inter-agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 Revision for Field Review," 2010.

²⁴ Emmus-IV Haiti 2005-2006, p. 14.

²⁵ These 85 percent were seen by a medical professional, which could include a medical doctor, a nurse, an auxiliary nurse, a health agent, a mid-wife or traditional birth attendant. Emmus-IV Haiti 2005-2006, p. xxix.

²⁶ Digests, "The Physical Accessibility of Health Facilities Strongly Affects Haitian Women's Use of Prenatal, Delivery Care," *International Family Planning Perspectives*, vol. 33, No. 1 (Mar., 2007), pp. 38-39.

²⁷ Emmus-IV Haiti 2005-2006, p. 14. The trend in the urban area may in fact be a decreasing number of women are seeking prenatal care, see, Haiti Maternal and Child Health and Family Planning Portfolio Review and Assessment, p. 11.

²⁸ Plan Interimaire du Secteur Santé: Avril 2010-Septembre, p. 1.

quintile.²⁹ A 2007 study found that security concerns, cost of transportation and other economic barriers, as well as expectations of poor care at public facilities, account for the low number of births attended by medical professionals.³⁰

Family Planning

Family planning plays an important role in reducing maternal mortality. Some studies suggest that using modern family planning methods has the potential to avert 32 percent of all maternal deaths and nearly 10 percent of childhood deaths, while at the same time decreasing rates of poverty and hunger.”³¹ As with rates of maternal mortality, Haiti experienced some backsliding with regard to progress in reproductive health in the last decade. While data demonstrate a dramatic increase in the use of contraceptives over a 40 year period, in 2005-06 only 28 percent of women and girls of reproductive age in urban areas, and 22 percent in rural areas, had access to modern methods of contraception.³²

Data indicate that use leveled off from 2003 to 2008, partly due to discontinuity in funding.³³ Family planning remains a neglected programmatic area in Haiti.³⁴

More women report a desire to space their next child, or to not to have any more children at all, than report using contraceptives: an estimated three out of every four women in a relationship in Haiti is a candidate for family planning, meaning, given access, these women are potential contraceptive users.³⁵ Moreover, 1 out of 10 adolescent girls in Haiti has had a child or is pregnant by the age of 17.³⁶

Even if a woman gains access to family planning, she may face other obstacles to using it. The ability of women and girls to make decisions about the number and spacing of children may be limited by their partners. According to one study, less than half of women in relationships reported being able to independently make decisions about contraceptive

²⁹ Ibid., p. 2.

³⁰ The Long Wait: Reproductive Health Care in Haiti, p. 11.

³¹ Inter-agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 Revision for Field Review, p. 99 (citing John Cleland et al., “Family planning: the unfinished agenda,” *The Lancet: The Lancet Sexual and Reproductive Health Series*, October 2006).

³² Plan Interimaire du Secteur Santé, p. 1.

³³ Haiti Maternal and Child Health and Family Planning Portfolio Review and Assessment, p. 11.

³⁴ Ibid., p. 7.

³⁵ Emmus-IV Haiti 2005-2006, p. 97.

³⁶ Haiti Maternal and Child Health and Family Planning Portfolio Review and Assessment, p. 7.

use, and 26 percent reported that their partner alone made decisions for them about their own health.³⁷

Gender-Based Violence (GBV)

Gender-based violence is common in Haiti.³⁸ Over the past two decades, high rates of domestic and sexual violence against women and girls exacerbated already high levels of economic and political insecurity. Furthermore, various regimes in Haiti have used sexual violence as a tool of repression. Some evidence suggests that politically motivated sexual violence occurred under the dictatorships of François and Jean-Claude Duvalier between 1957 and 1986.³⁹ Human Rights Watch and other organizations documented the use of rape and assault as a form of political oppression during the Cédras regime and post-coup period from October 1991 to May 1993. By 2000, criminal gangs used sexual violence and threats of sexual violence to terrorize communities.⁴⁰

In the 2004 to 2006 political conflicts, “widespread and systematic rape and other sexual violence against girls” remained a concern.⁴¹ The UN estimated that up to 50 percent of girls living in conflict zones in Port-au-Prince were victims of rape or sexual violence, with reports of widespread collective or “gang” rape.⁴² A survey of the metropolitan area found that 3.1 percent of women and girls, or an estimated 35,000, were sexually assaulted from

³⁷ Emmus-IV Haiti 2005-2006, p. 278.

³⁸ World Bank, *A Review of Gender Issues in the Dominican Republic, Haiti and Jamaica* (Washington DC: World Bank, 2002), p. 35; see also, UN Commission on Human Rights, Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences, Radhika Coomaraswamy, submitted in accordance with Commission on Human Rights resolution 1997/44. Addendum: Report on the mission to Haiti, 27 January 2000, E/CN.4/2000/68/Add.3, <http://www.unhcr.org/refworld/docid/3boof42ec.html> (accessed 23 May 2011), p. 10. Gender-based violence is defined as “violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.” See UN Committee on the Elimination of Discrimination against Women, General Recommendation 19, Violence against Women, (Eleventh session, 1992), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, UN Doc. HRI/GEN/1/Rev.1 (1994), p. 84, para. 6.

³⁹ Human Rights Watch, *Haiti’s Rendezvous with History: The Case of Jean-Claude Duvalier* (New York: 2011), pp. 22-23.

⁴⁰ Human Rights Watch/National Coalition for Haitian Refugees, *Rape in Haiti: A Weapon of Terror*, (New York: 1994). Even after the de facto regime was replaced with the democratically elected President Aristide, high rates of violence against women continued. According to statistics from the Ministry for the Status of Women, between November 1994 and June 1999, there were 500 registered cases of sexual harassment, 900 cases of sexual abuse and aggression against adult women, and 1,500 cases of sexual violence against girls between the ages of 6 and 15. See also Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences, Radhika Coomaraswamy, p. 12.

⁴¹ UN Security Council, Children and Armed Conflict-Report Of The Secretary General, U.N. DOC No. A/61/529-S/2006/826, (October 26, 2006), para. 39.

⁴² Ibid.; see also ActionAid, “MINUSTAH: DDR and Police, Judicial and Correctional Reform in Haiti: Recommendations for change,” 2006, p. 7.

February 2004 to December 2006, with over half of all victims younger than 18 years old, and almost 1 in 6 aged less than 10 years of age.⁴³

A Médecins Sans Frontières (MSF) facility in Port-au-Prince provided treatment to 500 rape survivors during roughly the same period (January 2005 to June 2007). Its statistics also reveal that a significant proportion of the victims of sexual violence were girls: 2 percent of the victims were under 5 years old; 10.6 percent were between 5 and 12; and 27.5 percent were between 13 and 18. MSF also found that 67 percent of victims did not know their attackers; 68 percent of victims reported multiple attackers; and 66 percent of victims were threatened with a gun.⁴⁴ The Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections (GHESKIO Center), a medical center in Port-au-Prince, reported treating 422 cases of rape in 2005; the same year women's organizations Solidarity of Haitian Women (Solidarité Fanm Ayisyen, SOFA) and Kay Fanm treated 112 and 188 cases of rape respectively.⁴⁵

In the 2005-06 EMMUS IV survey, more than a quarter of Haitian women and girls reported being victims of physical violence at least once since the age of 15, and 16 percent reported experiencing violence in the 12 months prior.⁴⁶ Just under a third of women indicated that their husband or partner perpetrated the violence. In the Port-au-Prince metropolitan area, 9.9 percent of women reported experiencing sexual violence. Haitian women also experience high levels of pregnancy-related violence, with more than 1 in 20 reporting to the EMMUS IV survey that they were subject to physical violence during their pregnancy: 40 percent of these women identified their husband or partner as the perpetrator.⁴⁷

Gender-based violence has a direct impact on women's health. A 2000 study found a correlation between the experience of spousal abuse and poor reproductive health outcomes, defined in the study as having a non-live birth, a sexually transmitted infection (STI) or symptoms of an STI, or having an unwanted birth.⁴⁸ A study in rural Haiti in 2005 found that "women whose current pregnancy was unplanned were 1.7 times more likely to have experienced forced sex," which is defined in the study as rape, sexual coercion, and

⁴³ Athena R. Kolbe & Royce A. Hutson, "Human Rights Abuse and Other Criminal Violations in Port-au-Prince, Haiti: A Random Survey of Households," *The Lancet*, vol. 368 (2006), p. 868.

⁴⁴ "Treating sexual violence in Haiti: An interview with Olivia Gayraud, MSF Head of Mission in Port-au-Prince," October 30, 2007, <http://web1.doctorswithoutborders.org/news/article.cfm?id=2135> (accessed June 21, 2011).

⁴⁵ Ministère à la Condition Féminine et aux Droits des Femmes et Ministère de la Santé Publique et de la Population, "Plan Nationale de lutte contre les violences faites aux femmes," November 2005.

⁴⁶ *Emmus-IV Haiti 2005-2006*, p. 299.

⁴⁷ *Ibid.*, pp. 298-305.

⁴⁸ Sunita Kishor and Kiersten Johnson, "Reproductive Health and Domestic Violence: Are the Poorest Women Uniquely Disadvantaged?" *Demography*, vol. 43, no. 2 (2006), p. 300.

other forms of sexual violence.⁴⁹ The same study found strong correlations between sexually transmitted infections and forced sex. Several symptoms related to sexually transmitted infections, including chronic pelvic pain, excessive vaginal discharge, discolored vaginal discharge, burning or pain when urinating, and lesions around the mouth or vagina, were found to be associated with a history of forced sex. The survey data from 2005 to 2006 confirmed this, finding the number of women who reported a sexually transmitted infection to be significantly higher among women who had experienced sexual violence.⁵⁰ A 2009 study of youth aged 15 to 24 found sexual violence to be a significant risk factor for pregnancy.⁵¹ In a 2008 report, Amnesty International found that approximately 20 percent of girls seeking treatment for rape at a medical facility in Port-au-Prince became pregnant.⁵² Moreover, for pregnant women the odds of a terminated pregnancy, defined as an abortion, miscarriage, or still birth, were significantly higher for women who report intimate partner violence.⁵³

In response to the growing threat of violence against women and girls, the Women's Ministry launched a National Plan to Fight Violence Done Against Women.⁵⁴ The five-year plan was developed in collaboration with the Women's Ministry, women's NGOs, and UN agencies. This tripartite coordinating body, known as the Concertation Nationale Contre Les Violence Faites Aux Femmes (Concertation Nationale), sought to develop and implement an effective and participative response to violence against women.⁵⁵ Major successes of the Concertation Nationale include helping to pass the 2005 decree modifying the penal code, making rape a crime, and establishing a policy that all victims of sexual aggression can receive medical certification of sexual violence at any medical facility. The lack of a certificate was found to be a major obstacle for women to press charges in cases of rape.

⁴⁹ M.C. Smith, Fawzi, et al., "Factors associated with forced sex among women accessing health services in rural Haiti: implications for the prevention of HIV infection and other sexually transmitted diseases," *Social Science & Medicine*, vol. 60 (2005) pp. 683-84.

⁵⁰ Contreras, J. M.; Bott, S.; Guedes, A.; Dartnall, E., *Sexual violence in Latin America and the Caribbean: A desk review*, (2010), p. 36 (citing *Emmus-IV Haiti 2005-2006* and Gómez, A. M.; Speizer, I. S.; Beauvais, H. "Sexual violence and reproductive health among youth in Port-au-Prince, Haiti," *Journal of Adolescent Health*, vol. 44 (2009), pp. 508-510).

⁵¹ Gómez, A. M.; Speizer, I. S.; Beauvais, H., "Sexual violence and reproductive health among youth in Port-au-Prince, Haiti," *Journal of Adolescent Health*, vol. 44. (2009) pp. 508-510, at 509.

⁵² Amnesty International, "Don't Turn Your Back on Girls: Sexual Violence Against Girls in Haiti," 2008, p. 19 (citing Médecins Sans Frontières, MSF Briefing Paper, A perilous journey: The obstacles to safe delivery for vulnerable women in Port-au-Prince, May 2008, p. 19, http://www.msf.ca/fileadmin/documents/publications/MSF_HaitiReport_ENG_R3.pdf).

⁵³ USAID, "Intimate Partner Violence Among Couples in 10 DHS Countries, Predictors and Health Outcomes," DHS Analytical Studies 18, December 2008 (prepared by Michelle J. Hindin, Sunita Kishor, Donna L. Ansara), p. 63. Terminated pregnancy is defined in this study as an abortion, miscarriage or stillbirth.

⁵⁴ Concertation Nationale Contre Les Violences Faites Aux Femmes, "Prévention, Prise en Charge et Accompagnement des Victimes de Violences Spécifiques Faites aux Femmes: 2006-2011," November 2005.

⁵⁵ *Ibid.*

Reforms and Efforts to Reduce Maternal Mortality before the Earthquake

The Haitian government had taken a number of steps to address the maternal and reproductive health crisis. The Ministry of Public Health and Population (MSPP) included maternal health as one of its priorities and the government included the reduction of maternal mortality as an important goal in its 2007 Growth and Poverty Reduction Strategy paper.⁵⁶ The MSPP's 2005 National Strategic Plan for the Reform of the Health Sector (*Plan Stratégique National pour la Reform du Secteur de la Santé*), included maternal and reproductive health in its strategy to deliver basic integrated health services through Haiti's public health system.⁵⁷

The cost of obstetric care was identified as a primary factor preventing women and girls from accessing care, contributing to Haiti's high maternal mortality rate.⁵⁸ In 2008, MSPP, along with Pan-American Health Organization/World Health Organization (PAHO/WHO) and the Canadian International Development Agency (CIDA), launched a program called the Free Obstetric Care project (Soins Obstétricaux Gratuits, SOG) in 49 institutions throughout the country. Still in operation, the project expands access to free prenatal and obstetric care.⁵⁹ It is a fundamental component of the national strategy for safer motherhood, which was nearly 100 percent donor-supported. Just one month after the project began the number of births in participating institutions increased between 51 and 224 percent.⁶⁰ Later data suggest that the number of maternal deaths in participating institutions was almost five times lower than the nationwide rate.⁶¹

Midwives, or skilled birth attendants, are also seen as an important component in decreasing maternal death. A school for midwives was established in 2001, graduating about 35 midwives each year. In addition, the UN Population Fund (UNFPA) supported programs to train traditional birth attendants, women who assist with deliveries, but have no formal medical training, to become auxiliary midwives. The Free Obstetric Care project

⁵⁶ International Monetary Fund, *Haiti's Growth and Poverty Reduction Strategy Paper* (IMF Publications: Washington, D.C., 2007), pp. 43-44.

⁵⁷ Minister of Public Health and Population (MSPP), "Plan Stratégique National pour la Reform du Secteur de la Santé 2005-2010," 2005, pp 42-49. See Haiti Maternal and Child Health and Family Planning Portfolio Review and Assessment, p. 14. The health system is divided into three levels: the first level includes 600 primary health clinics and 45 community referral hospitals; the second consists of the departmental hospital of each of the 10 departments; and the third contains the six university hospitals, five of which are located in Port-au-Prince. The network of facilities is theoretically organized into 54 communal health units, each serving between 80,000-140,000 inhabitants of the unit with a mandate to deliver a minimum service package, which includes maternal health. Plan Interimaire du Secteur Santé, pp. 1-4.

⁵⁸ Doctors Without Borders, "MSF Briefing Paper: A Perilous Journey: The Obstacles to Safe Delivery for Vulnerable Women in Port-au-Prince," May 2008, p. 15.

⁵⁹ WHO, *Free Obstetric Care in Haiti: Making pregnancy safer for mothers and newborns* (WHO: Geneva, 2010).

⁶⁰ Haiti Maternal and Child Health and Family Planning Portfolio Review and Assessment, p. 12.

⁶¹ Free Obstetric Care in Haiti: Making pregnancy safer for mothers and newborns, p. 6.

(SOG) includes funding to reimburse traditional birth attendants for bringing women with high-risk pregnancies into medical facilities for delivery.

The Haitian government and donors identified other factors frustrating efforts to reduce maternal mortality and put mechanisms in place to address them. For example, the United State Agency for International Development (USAID) found that the highly centralized and poor health system management of the health ministry presented problems. The ministry, working with USAID, sought to address the management problems by building central level institutions and strengthening planning capacity at the department level.⁶²

Women's Health and the Health System after the Earthquake

The devastating earthquake that hit near Haiti's capital, Port-au-Prince, on January 12, 2010, decimated the health sector. Sixty percent of health facilities were damaged and 10 percent of health professionals were killed or emigrated. The headquarters of the Ministry of Health and Population Services (MSPP) was completely destroyed.⁶³ This damage was not only devastating for the health of Haitians living in the capital, but to the country as a whole since the bulk of Haiti's health system was concentrated in Port-au-Prince. Many of the educational facilities for medical professionals were also damaged or destroyed. The school for midwives was severely damaged and the state nursing school collapsed, killing over 150 of the next generation of nurses in Haiti.⁶⁴

Humanitarian aid actors responded quickly to fill gaps in the emergency phase, setting up free health facilities throughout the affected areas. The UN put in a cluster system through UN's Office for the Coordination of Humanitarian Affairs (OCHA), which allows for the coordination of humanitarian actors throughout a variety of sectors, including protection, health, nutrition, and water and sanitation. Over 400 health NGOs participated in the response efforts through the health cluster. Many believed that despite the dire conditions left by the earthquake some health indicators would actually improve because of the influx of health professions and free health services. But almost 9 months after the earthquake, a study found that only 20 percent of camps had any sort of health facility on site.⁶⁵

⁶² Haiti Maternal and Child Health and Family Planning Portfolio Review and Assessment, p. 8.

⁶³ Plan Interimaire du Secteur Santé, p. 4.

⁶⁴ UNFPA, "Midwifery and Nursing Schools Destroyed by Earthquake in Haiti," January 22, 2010, <http://www.unfpa.org/public/news/pid/4756> (accessed July 29, 2011).

⁶⁵ Mark Schuller, "Unstable Foundations: Impact of NGOs on Human Rights for Port-au-Prince's Internally Displaced," October 4, 2010, p. 14.

Humanitarian groups recognized the urgent need to provide family planning services to women and girls in the aftermath of the quake. As early as January 19, 2010, they began calling for access to free contraceptives for women and girls.⁶⁶ By May 2010, the same groups called for all primary health care service providers, based on humanitarian standards, “to ensure contraceptives are available to meet demand, including condoms, pills, injectables, emergency contraceptive pills and intrauterine devices, as well as long-acting methods and permanent methods, as part of the recovery phase.”⁶⁷

Some medical NGOs operating in camps provided these services. The Haitian Group for the Study of Kaposi’s Sarcoma and Opportunistic Infections (GHESKIO) manages a camp located across from its facilities. A primary objective of its health strategy in the camp was to provide services to reduce maternal mortality and unwanted pregnancies and to provide services for victims of sexual violence. In the first 12 months after the earthquake, GHESKIO provided 57 trainings on family planning, educating 5,682 persons living in the camp on the use of contraception, preventing STIs, and sexual violence.⁶⁸ Providing services in camps allows women and girls direct access to the reproductive health services they need.

This is particularly important since, as Dr. Gadner Michaud of the women’s health organization PROFAMIL told Human Rights Watch, leaving the camps to seek care is very difficult for women. “Theft has increased,” he said. “People lost everything in the earthquake, and it is difficult to leave the camps to search for care because women may lose what few possessions they have left if they leave.”⁶⁹ PROFAMIL provided services in several camps for almost 10 months after the quake, but found it was difficult to provide quality reproductive health services in the camps. One concern was the lack of privacy and confidentiality for women and girls, which Human Rights Watch also encountered.⁷⁰ PROFAMIL moved from the camps to fixed facilities nearby, hoping the better quality of their services and privacy would outweigh the risks women and girls face leaving camps to seek care. This is in line with PROFAMIL’s project, submitted to the Interim Haiti

⁶⁶ Statement of the Reproductive Health Response in Crises Consortium, “Haiti Response Must Address Health Needs of Women and Girls,” January 19, 2010, http://www.rhrc.org/Haiti%20statement_RHRC_3%2002%2010_Final_Final.pdf (accessed June 21, 2011). The Reproductive Health Response in Crises Consortium consists of American Refugee Committee (ARC); CARE ; Columbia University; International Rescue Committee (IRC); JSI Research and Training Institute (JSI); Marie Stopes International (MSI); and the Women’s Refugee Commission .

⁶⁷ CARE et al., “Four Months On: A Snapshot of 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,” May 2010, p. 4.

⁶⁸ Human Rights Watch interview with Dr. Mireille Peck, director of GHESKIO camp, January 19, 2011. See also, Rapport Programme Santé de la Reproduction, Campus GHESKIO, EDH, Janvier-Décembre 2010, prepared by Dr. Gessy Bellerive, on file with author.

⁶⁹ Human Rights Watch interview with Dr. Gadner Michaud, director of PROFAMIL, Port-au-Prince, February 3, 2011.

⁷⁰ Ibid.

Reconstruction Commission, to expand access to essential sexual and reproductive health services more broadly.

In spite of efforts by some humanitarian organizations, some women and girls told Human Rights Watch they did not have information about, or the means to practice, family planning. The unmet family planning need in Haiti prior to the earthquake was close to 40 percent, and funding for reproductive health during crises in Haiti had previously been inadequate.⁷¹ Some women told Human Rights Watch that they previously had not practiced family planning, but now wanted access to contraception, citing difficult living conditions as the main reason for their new interest. Some service providers similarly found that women were less reluctant to ask about, and more interested in, certain kinds of contraception, such as injection administered contraception.⁷²

Following the quake there was at first a decreased supply of maternal and obstetric health services, with high demand. NGOs that had a presence prior to the earthquake suffered losses. For example, Médecins Sans Frontières' emergency obstetric hospital was completely destroyed.⁷³ In February 2010, the UN's Office for the Coordination of Humanitarian Affairs (OCHA) estimated that of the approximately 3 million people affected by the quake, some 63,000 were pregnant women and 114,000 were lactating mothers. It indicated an estimated 15 percent of pregnant women would require some emergency obstetric care.⁷⁴

In spite of their losses, many of the medical NGOs operating in the emergency phase, including Médecins Sans Frontières, Médecins du Monde, Partners In Health/Zanmi Lasante, and Save the Children, provided medical services, including maternal care, for free. The Free Obstetric Care project (SOG) also continued to operate, despite suffering the loss of offices, computers, and damage to participating medical institutions.⁷⁵

⁷¹ The Long Wait: Reproductive Health Care in Haiti, p. 7.

⁷² Priority Reproductive Health Activities in Haiti: An Inter-agency MISP Assessment, p. 20.

⁷³ The destruction from the earthquake led to some new public/private partnerships to form. Maternité Issaie Jeanty Hospital (Chancerelles) participates in the SOG program. After MSF lost its emergency obstetric hospital, it moved in to support Chancerelles as a referral hospital. Human Rights Watch interview with Sylvain Groulx, chief of mission, MSF-Holland, Port-au-Prince, January 27, 2011.

⁷⁴ OCHA, *Haiti Revised Humanitarian Appeal*, Feb. 18, 2010, p. 15, [http://ochadms.unog.ch/quickplace/cap/main.nsf/h_Index/Revision_2010_Haiti_FA/\\$FILE/Revision_2010_Haiti_FA_SCREEN.pdf?OpenElement](http://ochadms.unog.ch/quickplace/cap/main.nsf/h_Index/Revision_2010_Haiti_FA/$FILE/Revision_2010_Haiti_FA_SCREEN.pdf?OpenElement) (accessed July 31, 2011).

⁷⁵ By July 2010, the program returned to paying costs associated with all the entitlements of the program, including reimbursements for the costs of transport and fees for traditional birth attendants who bring women to medical facilities for delivery. The program saw no increases in maternal mortality during this period in the Port-au-Prince area, but experienced a slight increase in infant death. The program also saw an increase in births in its institutions overall. Some handled as many as 40 percent more cases, with the same number of resources prior to the earthquake. SOG experienced almost no

Public health professionals began noting a “pregnancy bubble” or an increase in pregnancies in the first three months after the quake.⁷⁶ A pregnancy bubble after a natural disaster is not uncommon and may be attributable to a variety of causes. Women and girls interviewed by Human Rights Watch identified some of the following factors for their own pregnancy: a desire to compensate for the loss of a child in the earthquake; the hope of strengthening a relationship with a new partner; and a lack of access to information or to methods of contraception. A number of those interviewed also reported rape as the cause of their pregnancy.

An October 2010 UNFPA-funded study found a pregnancy rate of 12 percent in the displacement settlements, 3 times the average urban rate before the earthquake.⁷⁷ Two-thirds of the pregnancies were unplanned and unwanted.⁷⁸ The exact number of currently pregnant women still displaced by the earthquake is unknown. The data clearly demonstrate that a high proportion of women and girls living in the camps require access to prenatal, obstetric, and postnatal care.⁷⁹

Haiti’s Human Rights Obligations

The earthquake did not change the human rights obligations of the Haitian government, which continues to have a duty to respect and protect human rights, which it must discharge without discrimination.⁸⁰ With regards to the right to health, these obligations should be understood as including special attention to the health needs of women and girls, i.e., “access to health services and the provision of at least priority sexual and reproductive health services including actions to prevent maternal morbidity and mortality, prevent and clinically manage cases of sexual violence [...]; [and] access to reproductive and specialized health services, including family planning and emergency obstetrical care.”⁸¹

interruptions in its supply chain for medications and supplies, although not all of the participating institutions picked up their supplies. Human Rights Watch interview with Dr. Laurent Stien, SOG program director, Port-au-Prince, February 2, 2011.

⁷⁶ Human Rights Watch telephonic interview with Sarah Marsh, Coordinator of Women’s Health, Partners In Health-Haiti, September, 18, 2010.

⁷⁷ UNFPA, “GOUDOUGODOU: Timoun Boum (Enquête sur l’évaluation des besoins et services de santé de la reproduction dans les zones affectées par le séisme – Oct 2010),” October 2010; Minister of Public Health and Population (MSPP) & l’Institut Haïtien de l’Enfance (IHE), “*Goudougoudou - Timoun boum*: Enquête sur la santé dans les sites d’hébergement-Haïti,” October 2010, released July 2011.

⁷⁸ UNFPA presentation, OCHA Reproductive Health Subcluster, January 26, 2011, notes and powerpoint from presentation on file with author.

⁷⁹ The number of births at Chancerelles increased from a low of 513 births in September 2010 to 1,207 in November 2010. Human Rights Watch interview with Nurse Caillot, R.N., chief nurse, Chancerelles Obstetric Hospital, Port-au-Prince, January 26, 2011.

⁸⁰ See, e.g., Inter-Agency Standing Committee, “IASC Operational Guidelines on the Protection of Persons in situations of Natural Disasters,” January 2011, p.12.

⁸¹ *Ibid.*, p.35.

However the capacity of the Haitian state to act in terms of available resources, and the need to rely on international assistance and cooperation, is a legitimate factor in assessing what measures Haiti is reasonably expected to implement.

Haiti is party to several international human rights treaties that create binding obligations on the government to improve women's health, including maternal and reproductive health, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Convention on the Rights of the Child (CRC), the International Covenant on Civil and Political Rights (ICCPR), the American Convention on Human Rights, and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women.⁸² Haiti has also signed, but not ratified, the Additional Protocol of the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador).⁸³

The UN Commission on Human Rights (now the Human Rights Council) and the UN special rapporteur on the right to health have consistently stated that the right to health includes the right to sexual and reproductive health, including maternal health, the right to health care, and to the underlying determinants of health.⁸⁴

To address its obligations after the earthquake, the Haitian government included maternal health in its recovery plan and sought to provide, or encourage non-state actors to provide, free prenatal and obstetric care. Removing financial barriers to health care is an essential measure to enable access to health services for poor and vulnerable groups.

⁸² Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), G.A. res. 34/180, entered into force, September 3, 1981, ratified by Haiti on July 20, 1981; Convention on the Rights of the Child (CRC), G.A. res. 44/25, U.N. Doc. A/44/49, entered into force September 2 1990, ratified by Haiti on June 8, 1995; International Covenant on Civil and Political Rights (ICCPR), G.A. res. 2200A (XXI), 999 U.N.T.S. 171, entered into force, March 23, 1976, ratified by Haiti on February 6, 1991; American Convention on Human Rights ("Pact of San Jose", Costa Rica), adopted on November 22, 1969 by the Inter American Specialized Conference on Human Rights, OAS Treaty Series, No. 36, entered into force on July 18, 1978, ratified by Haiti on September 14, 1977, Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women ("Convention of Belém do Pará"), adopted September 6, 1994, by the General Assembly of the OAS, entered into force May 3, 1995, ratified by Haiti on April 7, 1997.

⁸³ Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador"), adopted November 17, 1988, by the General Assembly of the OAS, OAS treaty Series 90, entered into force November 16, 1999, signed by Haiti on November 17, 1988. As a signatory, even though it has yet to ratify, the Haitian government must refrain from any action that would contradict the object and purpose of the treaty. See Vienna Convention on the Law of Treaties (VCLT), art. 18, May 23, 1969, 1155 U.N.T.S. 331. Moreover, the government of Haiti has the obligation under customary international law to give effect to basic economic, social and cultural rights. See CESCR, Concluding Comments (Israel), E/C.12/1/Add.90 (May 23, 2003), ¶. 31 ("basic economic, social and cultural rights, as part of the minimum standards of human rights, are guaranteed under customary international law").

⁸⁴ See, e.g., Commission on Human Rights resolution 2003/28, preamble and para. 6; see also Report of the special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, February 2003, E/CN.4/2003/58, para. 25; Report of the special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, February 2004, E/CN.4/2004/49, paras.11, 29.

Human Rights Watch found that despite the government's attempts to remove the cost of care as a primary barrier, many obstacles remain that prevent women and girls living in displacement settlements in the Port-au-Prince metropolitan area from accessing the health care they need.

II. Obstacles to Maternal and Reproductive Health: Failure to Protect Women's and Girls' Rights

I don't want any more babies. Life is too hard in the camps.

—Yvonne, camp in Croix-des-Bouquets, January 22, 2011

More unplanned pregnancies increase the poverty in this camp...

—Margalie, camp in Croix-des-Bouquets, January 22, 2011

Gender inequality and violations of women's and girls' rights that existed before a disaster can worsen after a disaster. In particular, pregnant women and lactating mothers face increased hardships, as do women with disabilities and elderly women, due to constrained mobility and greater need for health services, food, and water.⁸⁵ However, women and girl survivors of natural disasters remain rights-holders, entitled to seek the realization of their basic human rights.

Lack of Access to Family Planning

Rachelle was a 17-year-old student when the earthquake hit. Terrified of the falling buildings, she immediately sought refuge in the open spaces of a public square in front of the Presidential Palace. She stayed in the spontaneous settlement that sprang up there and became pregnant while living in the camp. Though Rachelle did not reveal details regarding her relationship to the father of the child, she said:

Yes, I wanted to use family planning, but I wasn't able to get it. There was a clinic here [in the camp] and they had planning, but unfortunately the clinic closed.⁸⁶

Women and girls in Haiti like Rachelle should be able to decide if and when they want to be pregnant, even if they are living in displacement camps. It is their right to decide the number and spacing of their children.⁸⁷ Reproductive health services and family planning,

⁸⁵ Other pre-existing women's rights concerns likely to be compounded by the earthquake include women's access to credit, to livelihood, to education, and to participation in decision-making structures. In addition, existing women's rights concerns likely to worsen the impact of the quake on women include low literacy rates of women, disproportionately high rates of HIV infection in women and the feminization of poverty in Haiti.

⁸⁶ Human Rights Watch interview with Rachelle, camp in Champ de Mars, November 14, 2010, Port-au-Prince, Haiti

⁸⁷ CEDAW, art. 16(1)(e).

through a variety of contraceptive methods, allow them—as individuals or with their partners—to fulfill this right.⁸⁸

Human Rights Watch research suggests that some women and girls in displacement settlements are not able to make this choice for themselves. Human Rights Watch found that obstacles to family planning services included lack of access to information and the means to practice family planning. Women and girls interviewed by Human Rights Watch faced additional obstacles to effectively utilizing contraceptive methods that were available to them because of their inability to negotiate use of available contraception, namely condoms, with their partners.

Lack of Access to Information

Tamara, a 17-year-old mother, lives with her parents and brother in a camp in Delmas 33. She is sometimes scared in the camp because fights often break out between young men and strangers will pop into her tent if it starts to rain. Tamara became pregnant while living in the camp, but was reluctant to discuss the circumstances of the pregnancy. She did say:

Nobody told me about planning, but if I knew planning, I would use it. It's only I don't know.⁸⁹

Women and girls in Haiti have a right to access to health-related information.⁹⁰ The CEDAW Committee has indicated state parties have to “ensure, without prejudice and discrimination, the right to sexual health information, education and services for all women and girls.”⁹¹ For adolescent girls like Tamara health education includes access to information on preventing early pregnancy.⁹² Unfortunately, many women and girls interviewed by Human Rights Watch reported that they did not have timely access to information about family planning. They said that:

⁸⁸ Inter-agency Working Group on Reproductive Health in Crises, “Inter-agency Field Manual on Reproductive Health in Humanitarian Settings: 2010 Revision for Field Review,” 2010, p. 99. Access to family planning, as part of reproductive health, constitutes an “integral element of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” See Commission on Human Rights Resolution, 2003/28, preamble and para. 6.

⁸⁹ Human Rights Watch interview with Tamara, camp in Delmas 33, November 10, 2010.

⁹⁰ See, e.g., Committee on Economic, Social and Cultural Rights, “General Comment 14: The right to the highest attainable standard of health”, E/C 12/2000/4, August 11, 2000, para 12(b). For a more detailed discussion of the right of access to information, see Human Rights Watch, *A State of Isolation: Access to Abortion for Women in Ireland* (New York: 2010), pp. 45-47; see also CRC, art. 24(2)(e).

⁹¹ Committee on the Elimination of Discrimination against Women, “General Recommendation No. 24: Women and Health,” 1999, U.N. Doc. A/54/38/Rev.3, para. 18.

⁹² CRC, art. 28.

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

This evidence is consistent with data from the UN Population Fund (UNFPA), which indicate that 74 percent of persons living in displacement settlements reported a need for information regarding family planning. That number rose to 4 out of 5 respondents for the 25 to 29-year-old age group.⁹³

Many women and girls told Human Rights Watch that no organization provided information on family planning in the camps where they lived. While some women and girls interviewed by Human Rights Watch reported having access to information, some women and girls from each camp we visited reported having no access to information. Like Tamara, Lovely lives in a camp in Delmas 33. She has two children and recently gave birth to another. As she held her infant, she told Human Rights Watch, “I wish I had stopped from getting pregnant.”⁹⁴ She said she had not planned to have the baby she held, and had lacked information about contraception, which she would have used if only she knew how.

Information that was accessible to women and girls we interviewed living in camps often came too late to prevent unwanted pregnancy. Jessie, a 27-year-old woman with three children, including a 6-week-old infant, reported that she was only given information about family planning after becoming pregnant and at a medical facility seeking prenatal care.⁹⁵ Ellen, 17, lives alone in a camp in Mais Gaté with her first child and said information on family planning was only provided in the camp at the baby-friendly space run by an international NGO.⁹⁶ It was therefore available to women and girls who were already pregnant or had recently given birth.⁹⁷

Human Rights Watch found that many women and girls we interviewed relied on information provided by social networks rather than medical professionals on side effects and usage of different forms of family planning, often because they could not find that

⁹³ UNFPA, GOUDOUGODOU: Timoun Boum, p. 1.

⁹⁴ Human Rights Watch interview with Lovely, camp in Delmas 33, November 10, 2010.

⁹⁵ Human Rights Watch interview with Jessie, camp in Croix-des-Bouquets, January, 22, 2011.

⁹⁶ Human Rights Watch interview with Ellen, age 17, camp in Mais Gaté, November 10, 2010.

⁹⁷ Counseling on family planning is a requirement for participation in the SOG program. See Human Rights Watch interview with Dr. Laurent Stien, PAHO SOG Administrator, Port-au-Prince, February 2, 2011.

information easily. Several women admitted that they did not use family planning because friends or relatives had told them that it makes women feel bad, bleed, or gain weight. At least three women told Human Rights Watch that they had stopped using contraceptives because it caused bleeding that worried them. Widney said:

I was hemorrhaging in January after the earthquake [from the contraception I was on], and I went to the hospital. They gave me pills [to stop it] but it was useless.⁹⁸

Scared, Widney stopped taking oral contraception. Like the other two women interviewed, she became pregnant after discontinuing contraception.

Women also reported varying levels of knowledge about proper postpartum family planning. Tesol, a 22-year-old who attempted to abort a prior pregnancy, believed that she could not start contraceptives until her baby was walking because it would have a negative impact on the child.⁹⁹ Misinformation about family planning may lead to unwanted pregnancy and, more importantly, negatively impact a woman's health if she becomes pregnant too soon after giving birth.¹⁰⁰

The government of Haiti should ensure women and girls have access to health-related information. This includes access to information and advice on family planning and access to the information and education necessary so that they will be able to make and implement decisions about the number and spacing of children.¹⁰¹ The government may need to seek assistance from donor and NGO partners to fund and implement programs to ensure access to information, as it did in cholera-related informational campaigns.

Access to Contraception and the Right to Decide on the Number and Spacing of Children

Girls who don't have parents, it's easy to become pregnant.
They don't have resources and have to have relationships with
men to survive ... Condoms are available but they don't use them...
—Valmie, camp in Mais Gaté, January 23, 2011

⁹⁸ Human Rights Watch interview with Widney, camp in Champ de Mars, November 14, 2010. Widney was due to give birth in January 2011 and is 19 and has two other children.

⁹⁹ Human Rights Watch interview with Tesol, camp in Mais Gaté, Port-au-Prince, November 17, 2010.

¹⁰⁰ For example, the WHO recommends a 24 month interval between the birth of one child and conception of the next "to reduce the risk of adverse maternal, perinatal and infant outcomes." See USAID, "Family Planning Needs during the Extended Postpartum Period in Haiti," August 2007, p. 1.

¹⁰¹ CEDAW, art. 10(h) and 16 (1)(e).

Human Rights Watch found that some women and girls living in displacement camps could not physically access contraception when they needed or wanted it. For others, when some forms of contraception such as condoms were available, their partners refused to wear them, and the women and girls were unable to negotiate or demand they change their mind.

A human rights framework requires that health facilities, goods, and services be available, accessible, and of good quality, and provided without discrimination.¹⁰² In relation to sexual and reproductive health services, the special rapporteur on health has noted that this means goods and facilities should be available in adequate numbers, and should be physically accessible and affordable.¹⁰³ Most women and girls interviewed about family planning told Human Rights Watch that they did not have physical access to family planning, which they would use if they had access to it. A number of women and girls admitted they would have preferred not to have had their last child or to be pregnant, and would have used family planning to prevent the pregnancy. Rachele said:

I don't like the way I live. I am in a tent and I don't have anybody to help me. I would like to keep on with my studies after the delivery. I was not planning to get pregnant ... I was a student, but I didn't have access to family planning. I would like to become a nurse.¹⁰⁴

Some women and girls interviewed by Human Rights Watch knew where to access family planning services outside the camps, but stated that such services were physically inaccessible to them because it was difficult to leave due to reasons that varied from transportation costs, which without livelihoods is too expensive even if amounting to less than US\$1, to concerns about theft of property if they left their tent unattended. Charlot, a woman living in a camp in Delmas 33, explained that she knew where free care was available at a clinic in another camp, but it “is hard to get to...you have to pay for transportation.”¹⁰⁵

Condoms are more easily available in the camps, where a large number were reportedly distributed immediately after the earthquake.¹⁰⁶ Condoms are a reliable form of contraception and provide protection from sexually transmitted infections (STIs); however,

¹⁰² See, e.g., Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, February 2004, E/CN.4/2004/49, para. 41.

¹⁰³ Ibid.

¹⁰⁴ Human Rights Watch interview with Rachele, camp in Champ de Mars, November 14, 2010.

¹⁰⁵ Human Rights Watch interview with Charlot, camp in Delmas 33, November 10, 2010.

¹⁰⁶ See, e.g., Priority Reproductive Health Activities in Haiti: An Inter-agency MISP Assessment, p. 13.

their use requires the consent of both partners. Human Rights Watch found that many women and girls, particularly young girls, living in precarious camp conditions lacked the power to negotiate condom use with their partners.

Several camp committee members confirmed that, while available, condoms had not been widely used.¹⁰⁷ Many men interviewed by Human Rights Watch asserted that they prefer not to use condoms and expected their partners to protect themselves in other ways.

There is no contraception in the camp except condoms.... We [men] don't want to use [condoms]; we don't like them. [Sex] doesn't feel sweet when we use them. So, it's good for [women and] girls to have access [to other forms of contraception].¹⁰⁸

Evidence that Human Rights Watch documented, which is consistent with information from other sources, clearly indicates that provision of condoms in the camps as the only means for family planning does not ensure women and girls are able to exercise the right to decide on the number and spacing of children. The difficulty women and girls face to convince partners to use condoms is not unique to the camp setting. However, it is important that the government identify measures that it can take within its resources, including in conjunction with other actors, to remove barriers that women and girls face in displacement camps in accessing diverse information about family planning.

Illegal and Unsafe Abortion as a Response to Lack of Access to Family Planning

Abortion is not legal in Haiti.¹⁰⁹ However, with as many as 66 percent of all pregnancies in the displacement settlements unwanted or unplanned, some women and girls resort to traditional remedies and teas known for their abortive qualities to end their pregnancy.¹¹⁰ The drug misoprostol, used for gastric ulcers and to induce labor, is also easily available on the street market and can induce abortion. There is general knowledge on how it can be

¹⁰⁷ Human Rights Watch interview with Valmie, Mona, Chelnea, Rachlene, group interview with women's committee, camp in Mais Gaté, January 23, 2011.

¹⁰⁸ Human Rights Watch interview with Azor, camp in Croix-des-Bouquets, January 22, 2011. Azor was part of a group interview of the camp committee.

¹⁰⁹ CEDAW, Consideration of reports submitted by States under Article 18 of the Convention on the Elimination of All Forms of Discrimination against Women: combined initial, second, third, fourth, fifth, sixth and seventh periodic reports of States parties: Haiti, CEDAW/C/HTI/7, July 9, 2008, p. 81; and, Haitian Penal Code, art. 262.

¹¹⁰ Statistic on unplanned pregnancy taken from UNFPA presentation, OCHA Reproductive Health Subcluster, January 26, 2011, notes and powerpoint from presentation on file with author.

used.¹¹¹ The medical professionals Human Rights Watch interviewed all confirmed that they had witnessed an increase in the number of cases involving complications related to abortions induced by misoprostol.¹¹²

The medical director of the state gynecological and obstetric hospital noted that, although he could not provide specific numbers, he had seen a marked increase in the number of young women and girls who were coming to his facility with complications, including hemorrhaging, from illegal and unsafe abortions.¹¹³ While most cases at the hospital are complications from abortions induced by medication such as misoprostol, there are some extreme cases of infections where an unclean metal object was introduced into the uterus to induce the abortion.¹¹⁴ Maternité Issaie Jeanty Hospital (Chancerelles) has treated girls as young as 14 and 15 for infections and other complications related to unsafe abortions.¹¹⁵

Nurse Caillot, the head nurse at Chancerelles said:

We see a lot of [cases of complications due to] abortion, both from Cytotec [brand name for misoprostol] and instruments. This is a big problem for women's health. Women come in with infections that are dangerous.¹¹⁶

The hospital has also seen cases of women who already have several children and tried to abort their latest pregnancy.¹¹⁷ In many cases these women did not have access to family planning, so the hospital provides family planning after the abortion-related complications have been treated.¹¹⁸

The hospital could not provide Human Rights Watch with statistics on the number of complications due to abortion it treats each month, but the chief obstetric nurse noted

¹¹¹ Misoprostol is a drug designed to prevent certain kinds of gastric ulcers. It is also often used to induce labor, but can be used earlier in a pregnancy to induce abortion. Misoprostol can be a relatively safe option for a medical abortion; however, taken too late or in too high a dosage, can cause heavy bleeding that can be dangerous. Human Rights Watch telephone interview with Sarah Marsh, coordinator of Women's Health, Partners In Health-Haiti, September 18, 2010.

¹¹² See, e.g., Human Rights Watch interview with Dr. Lise-Marie Déjean, medical director Solidary of Haitian Women (known by its Kreyòl acronym SOFA), November 16, 2010.

¹¹³ Human Rights Watch interview with Dr. Camille Figaro, medical director, Chancerelles Obstetric Hospital, Port-au-Prince, January 21, 2011.

¹¹⁴ Ibid.

¹¹⁵ Human Rights Watch interview with Nurse Caillot, R.N., chief obstetric nurse, Chancerelles Obstetric Hospital, Port-au-Prince, January 26, 2011. Refugees International reported that girls as young as 10 years-of-age had been treated in some medical facilities for complications related to abortion.

¹¹⁶ Ibid.

¹¹⁷ After the woman or girl is treated for the infection, they are counseled on different methods of family planning. Ibid.

¹¹⁸ Ibid.

that the hospital had performed approximately three hysterectomies that year on women who arrived with advanced infections due to unsafe abortions.¹¹⁹ The Hospital Universitaire de la Paix (HUP) is another state hospital that provides obstetric care, but treats about one-fifth of the number of pregnant women that Chancerelles sees. HUP reported treating eight incomplete abortions in December 2010, the last month for which it could provide data.¹²⁰ The General Hospital (HUEH) did not have formal intake data available on women and girls treated for complications arising from incomplete abortions. However, hospital staff told Human Rights Watch that, in their view, the hospital has treated an increased number of patients with complications arising from unsafe abortions since the earthquake.¹²¹

Tesol explained how she took the risk of having an unsafe, illegal abortion because the pregnancy was unplanned and she had no means to care for the child.

I took a lot of medication to abort this baby. Because the medication didn't work, that's why I gave birth. I took a beer and a medication that cost US\$3.15. I got the drugs at a pharmacy. A person, a friend, told me about it.... [Then] I was unconscious; I had fainted.... The doctor had told me if I abort, I will have a problem, because I was four months pregnant. The doctor didn't help me have the abortion; he told me it was illegal.¹²²

Tesol told Human Rights Watch that even after this experience and then giving birth in the hospital, she felt she did not have adequate access to contraception, exposing her to the risk of another unwanted pregnancy.

Before the earthquake, the CEDAW Committee noted with concern the frequent use of abortion as a family planning measure in Haiti. It called upon the government to provide wide access to contraceptives and to develop programs for sex education to “avoid the need for women to resort to illegal abortions.”¹²³ Resorting to illegal abortion in unsafe conditions, as the Human Rights Committee has noted, may endanger “the life and health of the women concerned.”¹²⁴ Abortions in Haiti contribute significantly to the rate of

¹¹⁹ Ibid.

¹²⁰ Hôpital Universitaire de la Paix (HUP), Rapport du Mois de Décembre 2010.

¹²¹ Human Rights interview with Nurse Goudet, R.N., chief obstetric nurse, HUEH, January 19, 2011.

¹²² Human Rights Watch interview with Tesol, camp in Mais Gaté, Port-au-Prince, November 17, 2011.

¹²³ See Concluding Observations of the Committee on the Elimination of Discrimination against Women: Haiti, at 37, UN Doc CEDAW/C/HTI/CO/7 (2009).

¹²⁴ See Concluding Observations of the Human Rights Committee: Sri Lanka, at para. 12, UN Doc CCPR/CO/79/LKA (2003).

maternal mortality, with abortion linked to 13 percent of maternal deaths in Haiti.¹²⁵ Access to family planning for women and girls in displacement camps, to avert the demand for such abortions, is fundamental for the government to meet its obligations to reduce maternal mortality and ensure the highest attainable standard of health.

Obstacles Accessing Prenatal Care

When women and girls in Haiti do become pregnant, they have a right to prenatal care.¹²⁶ Prenatal consultations in the earthquake-affected areas are widely available for free or at a nominal cost due to the increase services by organizations such as Médecins Sans Frontières (MSF), Médecins du Monde, and Save the Children, as well as the increased use of the Free Obstetric Care project (SOG) facilities. Nevertheless, Human Rights Watch found that barriers other than the cost of the visit prevented some women and girls from accessing prenatal care or completing the four prenatal visits that the WHO recommends. These barriers include lack of knowledge related to the need for care, where to access it, and economic barriers not directly associated with the cost of a prenatal check-up, such as transportation or sonogram costs.

Lack of Access to Information

Ellen, a 17-year-old new mother in a camp in Mais Gaté, lost both her parents in the earthquake. She lives with her older sister in a tent in a displacement settlement near the airport. She became pregnant shortly after the earthquake. The father of the child has left her. She did not attend prenatal check-ups, and when she went into labor, she gave birth in the camp with her sister's help. She said she did not go to prenatal visits or to the hospital to give birth because it was her first child and she was inexperienced.¹²⁷

He's my first child and I didn't have anyone to give me advice to go to a clinic [for prenatal care].... I gave birth in the camp because no one told me to go to the hospital. No one helped me but my sister.¹²⁸

¹²⁵ See, PAHO, "Health in the Americas, 2007, Volume II – Countries, Haiti," 2007, p. 415. This is consistent with the global figures. See WHO, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008*, 6th ed. (WHO: Geneva, 2011), p. 1.

¹²⁶ See Commission on Human Rights Resolution, 2003/28, preamble and para. 6; see also CESCR, "General Comment 14: The right to the highest attainable standard of health," para 11, finding access to health-related information to be included in the right to health. CEDAW protects the right of women to receive appropriate services in connection with pregnancy. CEDAW, art. 12(2). Article 24 of the CRC further protects this right to prenatal care. CRC, art. 24(d).

¹²⁷ Human Rights Watch interview with Ellen, camp in Mais Gaté, Port-au-Prince, November 10, 2010.

¹²⁸ *Ibid.*

Ellen did not encounter any medical emergencies, but not knowing that she needed to seek care could have been lethal. The UN special rapporteur on health has noted that lack of access to information is one of the factors that make women more vulnerable to ill health.¹²⁹ The right of access to information and health-related education is a component of the right to prenatal care, as it is with family planning.¹³⁰

Early pregnancies, like Ellen's, can have a detrimental impact on health. Pregnant girls should have access to information about pregnancy, childbirth, and health services tailored to their particular needs.¹³¹

Nevertheless, in interviews with Human Rights Watch, women and girls—especially pregnant adolescent girls—who did not have prenatal care said they lacked access to information about the importance of care and where to seek it. The earthquake destroyed many of the neighborhood medical facilities where women previously sought care. After the earthquake many women and girls had settled in parts of the city or neighborhood unfamiliar to them, and were unsure where to seek care. Mardin lives in the displacement camp near the airport, and told Human Rights Watch she had gone for prenatal checkups when she was pregnant with her other children. With her latest pregnancy she did not go for prenatal care because the earthquake had decimated the hospital she had previously used.¹³² A doctor with years of experience in Haiti said:

The earthquake destroyed social systems and many of the physical reference points for communities disappeared: churches, small clinics, et cetera. People moved to new neighborhoods and the geography was completely changed. They didn't know what existed before, what clinics or hospitals, or what is available now. The daily struggle in the camps is difficult, and families can't foresee their health needs in the future. When the need arises, people don't know where to go. They ask other people, and

¹²⁹ UN Commission on Human Rights, "The right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Report of Special Rapporteur, Paul Hunt, submitted in accordance with Commission resolution 2002/31", E/CN.4/2003/58, February 13, 2003.

¹³⁰ CESCR, "General Comment 14: The right to the highest attainable standard of Health," para 12(b). For a more detailed discussion of the right of access to information, see *A State of Isolation: Access to Abortion for Women in Ireland*, pp. 45-47; see also CRC, art. 24(e).

¹³¹ CRC, General Comment No. 4 (2003), Adolescent health and development in the context of the Convention on the Rights of the Child, CRC/GC/2003/4, July 1, 2003, para. 31.

¹³² Human Rights Watch interview with Mardin, camp in Mais Gaté, January 23, 2011.

most only know the general hospital, which is too far and has a reputation for lacking drugs or doctors.¹³³

Human Rights Watch also found that a significant number of women and girls we interviewed who did not seek prenatal care encountered difficulties with their delivery. Setania became ill in the seventh month of her pregnancy. She was one of the lucky ones because she was able to reach the hospital and have her labor induced. She delivered a premature baby and at the time of the interview, she and her baby were recovering. Michelin however, did not seek antenatal care, and suffered a stillbirth in March 2010. She had not experienced problems during the pregnancy, so did not know she should have gone for prenatal checkups.¹³⁴

Information about the importance of prenatal care and where to seek it is important if maternal mortality is to be reduced via prenatal assistance.¹³⁵ The earthquake fundamentally changed the landscape of facilities providing prenatal care and forced some women and girls out of neighborhoods where they knew what health services were available. The government needs to identify targeted measures it can take to provide women and girls displaced by the quake with information necessary for accessing available care. This will require coordination with NGO and donor partners, both to establish what services are available and to disseminate accurate information regarding available services to women and girls.

Economic Accessibility

Vyola, a 27-year-old living in a camp in Delmas 33, told Human Rights Watch “[i]t was difficult to get to [prenatal] check-ups” because she had to go on foot.¹³⁶ Vyola would have had to walk about three kilometers on a busy main thoroughfare and up steep hills to go to prenatal checkups. This became more challenging as her pregnancy progressed. Yet, Vyola was happy she received free care.

For many women and girls interviewed by Human Rights Watch, removing the cost of prenatal visits alone was not sufficient to make it economically accessible. Instead, they discontinued their prenatal visits because of financial barriers, including the cost of

¹³³ Human Rights Watch interview with country director, large medical NGO, Port-au-Prince, January 20, 2011. Name withheld upon request.

¹³⁴ Human Rights Watch interview with Michelin, camp in Pétion-ville, January 30, 2011.

¹³⁵ See Committee on the Elimination of Discrimination against Women, “General Recommendation No. 24: Women and Health,” (20th Session, 1999), para. 31; CRC, art. 24(d).

¹³⁶ Human Rights Watch interview with Vyola, camp in Delmas 33, November 11, 2010.

transportation to health care facilities and the costs associated with a prescribed sonogram. Their experience reaffirms that to be ‘affordable’ in practice, means ensuring that “[p]ayment for health-care services, *as well as services related to the underlying determinants of health...whether privately or publicly provided, are affordable for all, including socially disadvantaged groups*” (emphasis added).¹³⁷

Transportation costs can render free prenatal care economically inaccessible in Haiti. Taxis and motorbike taxis (*motos*), costing a few US dollars, were too expensive for most women and girls by Human Rights Watch interviewed to use for prenatal checkups. Most women and girls reported either walking long distances to prenatal visits, or taking semi-public transportation (*taptaps*), which is usually cheaper than taxis.¹³⁸ Some reported not having money to afford even *taptaps*; others complained that as their pregnancy progressed, it became more difficult to walk to the medical facility or to ride in the *taptaps*. Those women and girls we interviewed able to access prenatal appointments on foot raised concerns about how they would access care when they are in labor. Anita, a 27-year-old living near Champ de Mars explained:

I go by foot to the hospital. It is a three-hour walk to the hospital. I don't have money to pay for a car. When I am in labor, I hope someone will pay for me.¹³⁹

Travel costs are reimbursable under the Free Obstetric Care project (SOG), which Anita did not know. A February 2011 review of the previous three months of the SOG project found that less than 8 percent of SOG participants utilized this component of the program; only 0.3 percent received reimbursement through SOG for transportation to the university hospital for prenatal care.¹⁴⁰ Evidence suggests women and girls may not know about this entitlement, as those women and girls interviewed by Human Rights Watch consistently said transportation was an obstacle to accessing care.

¹³⁷ This has been an issue on many occasions for the special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, see, e.g., Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/61/338, September 13, 2006, para. 17(b); CRC, art. 24(d). See, also e.g., CESCR, “General Comment 14: The right to the highest attainable standard of health,” para. 12.

¹³⁸ Owned and operated by private actors, *taptaps* are often old pickup trucks that have colorful wooden canopies attached to the bed of the truck and benches underneath; some are minivans.

¹³⁹ Human Rights Watch interview with Anita, camp in Champ de Mars, November 13, 2010. The general hospital is located nearer to this camp, but Anita did not seek care at that facility for reasons not explained.

¹⁴⁰ Institut de Consultation en Informatique, Economie et Statistique Appliquées, “Enquete de Satisfaction des Femmes Beneficiaires des Soins Obstetricaux Gratuits, Rapport du Deuxieme Trimestre de l’Evaluation (Novembre-2010/Decembre-2010/Janvier-2011),” February 2011, pp. 7 and 107.

Many women and girls we interviewed also reported that the cost of sonograms was a significant barrier to continuing access to prenatal care. While high-risk pregnancies can be diagnosed and monitored without sonograms, they are useful in “diagnos[ing] fetal death at any age, assess[ing] fetal well-being, evaluat[ing] amniotic fluid volume, and diagnos[ing] a broad variety of fetal malformations.”¹⁴¹

Sonograms are not available in most public clinics or health facilities, and women and girls must go to a private laboratory or facility to have one. Moreover, the SOG program does not include sonograms as a free part of care.¹⁴²

Human Rights Watch found that the costs of sonograms created an obstacle to care not because they are a necessary pre-condition for maternal health, but because many women and girls we interviewed thought they could not return for follow up care without the results from a sonogram. Some women and girls interviewed sought prenatal care at multiple facilities to avoid seeing the doctor who originally prescribed the sonogram, resulting in further and more expensive travel.

Several pregnant women and girls reported to Human Rights Watch that they discontinued prenatal visits altogether because they could not afford sonograms. Myrlande, a 22-year-old living in Champ de Mars, became pregnant after three men sexually assaulted her. She began prenatal care but stopped. She said:

[The doctors at the general hospital] gave me an appointment and told me to come back with the results of the sonogram.... I don't remember the last time I went to the doctor.... I would have kept going if I had had the sonogram.¹⁴³

Some women and girls who discontinued care like Myrlande also reported periodically having severe pain associated with their pregnancy.¹⁴⁴

¹⁴¹ William J. Watson and John W. Seeds, “Diagnostic Obstetric Ultrasound,” *Global Library of Women’s Medicine*, DOI 10.3843/GLOWM.10199, 2008. Indications for a sonogram during pregnancy include: vaginal bleeding during pregnancy, obstetric complications in a prior pregnancy, selected high-risk pregnancies to screen for fetal malformation and fetal assessments, and to follow fetal growth in certain high-risk situations.

¹⁴² Human Rights Watch interview with Dr. Laurent Stien, SOG program director, Port-au-Prince, February 2, 2011.

¹⁴³ Human Rights Watch interview with Myrlande, camp in Champ de Mars, November 14, 2010.

¹⁴⁴ See, e.g., Human Rights Watch interview with Anonymous, 19, camp in Champ de Mars, November 14, 2010; Human Rights Watch interview with Claudia, 16, camp in Mais Gaté, November 17, 2010.

In a small number of cases considered by Human Rights Watch, the cost of sonograms even impacted a woman's decision to seek obstetric care. Several women and girls interviewed said they believed they could not return to the same facility to give birth if they were unable to pay for the sonogram. Adeline described how she discontinued checkups because she could not afford the sonogram, and when she went into labor, she went to a hospital much further away because she did not think she could do so at the same facility she had gone for checkups.¹⁴⁵

Yvonne, 30, from a camp in Croix-des-Bouquets, also thought she could not give birth at the same hospital that had asked her to have a sonogram. She was resigned to giving birth in the camp but had to seek emergency obstetric care at a health facility after having difficulties in labor.

I went to several different hospitals for check-ups before I gave birth [because] ... when they asked me to do a sonogram, and I didn't have money to do the sonogram, I changed hospitals.... No one told me that I would have a difficult birth ... [but] I had pain when I went into labor. I arrived at the hospital at 9, at 10 I had not given birth, and by 11 I had the C-section.¹⁴⁶

Another woman, Benita, was also unable to pay for a sonogram that was prescribed for her and discontinued prenatal visits. Her baby died shortly after she gave birth in her tent.

While the Haitian government has taken important steps to remove the economic barriers to prenatal care by providing free care, costs still remain that prevent women from seeking the potentially life-saving care they need. Human Rights Watch found that ancillary costs to prenatal care continue to make prenatal care economically inaccessible for the most vulnerable women and girls it interviewed, frustrating the government's efforts. This is a problem that may not be isolated to the displacement camps, but that many women and girls in Haiti may face. Women and girls who are unable to access free prenatal care provided by the state because they cannot pay ancillary costs do not have the same access to these services as those who can pay these additional costs.

Obstacles Accessing Obstetric Care

When Tamara, the 17-year-old who wishes she had access to family planning, went into labor, she gave birth in her tent without the help of trained medical personnel. The tent

¹⁴⁵ Human Rights Watch interview with Adeline, camp in Croix-des-Bouquets, January 22, 2010

¹⁴⁶ Human Rights Watch interview with Yvonne, camp in Croix-des-Bouquets, January 22, 2010.

she shares with her family looks like an old canvas army tent with barely room for a cot. It is perched precariously on a slope and opens onto a narrow alleyway. Tamara wanted to go to the hospital, but when she went into labor, it was decided she would not have time to reach the hospital, so her mom helped her deliver the baby in the tent. Tamara mused, with little emotion “[i]t was really difficult to give birth in here.”¹⁴⁷

Women and girls like Tamara should be able to use the services of a skilled birth attendant and appropriate obstetric services, including emergency obstetric services and postnatal care, and receive free services where necessary.¹⁴⁸ As the Inter-American Commission for Human Rights has noted, “provision of adequate and timely maternal health services is one of the principal ways” to ensure women’s right to personal integrity with regards to health.¹⁴⁹

Human Rights Watch interviewed 75 women and girls who had already given birth at the time of the interviews. Over half of them had given birth somewhere other than a medical facility, with over a quarter of them delivering in a camp and others on the street on the way to the hospital without a skilled birth attendant. Overwhelmingly, women said they would have preferred to give birth in a hospital. Eighty-seven percent of pregnant women living in camps expressed the same preference to the UN Population Fund’s (UNFPA). For two cohorts of women, those aged 25 to 29 and 30 to 34, the number increases to 92 percent.¹⁵⁰

Human Rights Watch found evidence of the “three delays” that in many cases prevented women and girls from accessing the appropriate obstetric care: 1) women did not seek appropriate care because of a lack of recognition of the signs of labor and other information; 2) women did not reach appropriate facilities because of distance, concerns about security, or transportation costs; and 3) women did not receive adequate care when reaching a facility because they could not afford the cost of care or the facility lacked resources.¹⁵¹

¹⁴⁷ Human Rights Watch interview with Tamara, 17, camp in Delmas 33, November 10, 2010.

¹⁴⁸ See, e.g., CEDAW, art. 12(2); Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/61/338, September 13, 2006, para. 13. See also CESCR, “General Comment 14: The right to the highest attainable standard of health,” para 14.

¹⁴⁹ IACHR, *Access to Maternal Health Services from a Human Rights Perspective*, OEA/Ser.L/V/II.Doc. 69, para. 23 (2010), June 7, 2010. Article 10 of the Protocol of San Salvador, signed by Haiti provides that everyone has the right to health, understood as the enjoyment of the highest level of physical, mental and social well-being.

¹⁵⁰ GOUDOUGODOU: Timoun Boum, p. 2.

¹⁵¹ The “three-delay” framework was developed to understand the factors leading to preventable maternal mortality. See S. Thaddeaus and D. Maine, *Too Far to Walk: Maternal Mortality in Context*, Center for Population and Family Health (Columbia University School of Public Health: New York, 1990); see also, D. Barnes-Josiah, C. Myntti, and A. Augustin, “The “Three Delays” as a Framework for Examining Maternal Mortality in Haiti,” *Social Science Medicine*, vol. 46, no. 8 (1998), pp. 981-993. For a further discussion of the three delay model and human rights, see Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/61/338, September 13, 2006, para. 21.

Lack of Access to Information on When and Where to Access Obstetric Care

Founa, 21, gave birth in her tent in a camp in Pétion-ville. She told Human Rights Watch that she did not have time to go to the hospital because she went into labor very quickly.¹⁵² “The doctor did not talk to me about how to know when the baby was coming,” she said.¹⁵³ Many women and girls interviewed by Human Rights Watch said they wanted to give birth in hospitals, but did not have time to get to health facilities once they went into labor. Human Rights Watch found that often the lack of timing was related to not having information about the signs of early labor and where to go for care and how to do so. Others reported speaking to the doctor about signs of labor, but also appeared confused about the information provided.

Carlene, 28, who lives in a camp in Pétion-ville, was in labor for almost a day before going to the hospital to seek care:

I was in labor for a day. I was at home first, but I knew to go to the hospital when I felt my bellyache. The doctor talked to me about the signs of labor and to go to the hospital. The head of the child was outside of my vagina when I got to the hospital.¹⁵⁴

Had Founa, Carlene, or the other women and girls interviewed who did not recognize signs of labor, encountered an obstetric emergency, the delay in seeking care created by that lack of information may have cost them their lives.

For Vania, a woman living in a camp in Mais Gaté, this lack of information may have contributed to her child’s death. Vania gave birth in October 2010 on the floor of her tent. She was alone in her tent when she went into labor. She did not know the date she was going to give birth, but she did know she had hypertension. By the time she recognized that she was in labor it was too late to go to a hospital. A friend from her church helped her give birth, but the baby died shortly after. Vania does not know why the baby died. She had no postnatal care and has not seen a doctor since she gave birth.¹⁵⁵

Human Rights Watch found that some women and girls we interviewed also lacked information about where to give birth. In post-earthquake Haiti, developing a birth plan,

¹⁵² Human Rights Watch interview with Founa, camp in Pétion-ville, January 30, 2011.

¹⁵³ Ibid.

¹⁵⁴ Human Rights Watch interview with Carlene, camp in Pétion-ville, January 30, 2011.

¹⁵⁵ Human Rights Watch interview with Vania, camp in Mais Gaté, January 23, 2011.

including where to go to give birth, is important. Eighty-one percent of medical facilities interviewed by the UN Population Fund in October 2010 provided prenatal care, but only 22 percent were equipped to provide obstetric services. Thus, the majority of women that have access to prenatal care at one facility must choose a different facility to give birth. Few women or girls we interviewed had discussed a birth plan with their doctor.¹⁵⁶ Thus, when these women or girls went into labor or encountered difficulty with their delivery, some did not know where to go to receive free or emergency care.

Human Rights Watch found that lack of access to information is a primary factor in delaying some women and girls from seeking appropriate care and that the Haitian government should identify measures it can take within its available resources to address this lack of access to information. It should also work with NGO and donor partners to develop and fund programs to fill informational gaps the government lacks the capacity to address.

Obstacles to Accessing Available Obstetric Care

Before the earthquake, Claire had been assisted by skilled birth attendants when she went into labor with her first five children. But she was living in a camp in Delmas 33 when she went into labor with her sixth child, and gave birth alone in her tent. Claire told Human Rights Watch: “The tent causes trouble and diseases. I wouldn't give birth in the tent [if I didn't have to].”¹⁵⁷ The earthquake displaced Claire to a new neighborhood she did not know well. She was uncomfortable leaving the camp on foot at night, and had no money for transportation.

No one helped me with this one. God gave birth to him, though, because there were no problems. God helped me, and I didn't have to leave the camp at night. [Otherwise,] I would have needed a car; I would have had to pay transportation.¹⁵⁸

Human Rights Watch found that women and girls like Claire encountered barriers to accessing available obstetric care, including emergency care, because of the cost and availability of transportation. In a small number of cases, women and girls also reported to

¹⁵⁶ However, the SOG project found that a large majority of participants in the project reported discussing a birthing plan with doctors. See generally Institut de Consultation en Informatique, Economie et Statistique Appliques, “Enquete de Satisfaction des Femmes Beneficiaires des Soins Obstetricaux Gratuits, Rapport du Deuxieme Trimestre de l’Evaluation (Novembre-2010/Decembre-2010/Janvier-2011),” February 2011.

¹⁵⁷ Human Rights Watch interview with Claire, camp in Delmas 33, November 10, 2010.

¹⁵⁸ Ibid.

Human Rights Watch that concerns about their safety delayed or prevented them from traveling to the hospital when they went into labor at night.¹⁵⁹

When 23-year-old Benita went into labor, she did not have money to get to a hospital. She gave birth in the camp she lived in near Mais Gaté: her baby died less than 24 hours later.¹⁶⁰ Benita said:

The hospitals are free, but you have to pay for transportation, and I didn't have that.... It was difficult. I suffered much.... At four in the afternoon I went into labor, I gave birth at 7 p.m. The baby died the day after at two in the afternoon. He did everything right ... no problems ... but then he was dead. We didn't call an ambulance or go to the hospital. We went for a funeral instead. [Neither his birth or his death was registered]. It was difficult for me.¹⁶¹

Like Benita, many of the women and girls interviewed by Human Rights Watch who gave birth in the camps had no care other than what a family member or friend could provide. Several women reported delivering alone and only having assistance when cutting the umbilical cord. Elimsie, a 37-year-old woman living in a camp in Mais Gaté, explained, “I gave birth in my tent ... the moment I gave birth to the baby, they called for the midwife who cut the umbilical cord.”¹⁶² There was no midwife available when Virginie gave birth, so according to her, she “just cut the cord” herself.¹⁶³

Mona’s sister recently died in childbirth. Her sister lived somewhere outside of the camp in Delmas 33 where Mona, 36, lived and also recently gave birth. She did so in her tent, without any assistance. “I just gave birth on the ground,” she said. “I had no drugs for pain during delivery. I saw a doctor three days later, and he gave me acetaminophen.”¹⁶⁴

¹⁵⁹ Shetland, 19, from a camp in Champ de Mars, illustrates how security concerns may delay seeking care. Shetland did reach a health facility to give birth; however, she went into labor at 2 a.m. and waited to seek care at the hospital until 6 a.m. She did not have money for transportation and was afraid to walk to the hospital at night. She did reach the facility in the morning, but she described to Human Rights Watch how difficult it was: “I walked by foot. Took a lot of time; I was already in labor walking there; I didn't have \$ to pay for a car...” Human Rights Watch interview with Shetland, camp in Champ de Mars, November 14, 2010.

¹⁶⁰ Human Rights Watch interview with Benita, camp in Mais Gaté, January 23, 2011.

¹⁶¹ Ibid.

¹⁶² Human Rights Watch interview with Elimsie, camp in Mais Gaté, Port-au-Prince, November 17, 2010.

¹⁶³ Human Rights Watch interview with Virginie, camp in Champ de Mars, November 14, 2010.

¹⁶⁴ Human Rights Watch interview Mona, camp in Delmas 33, November 9, 2010.

Unlike Mona, most of the women and girls we interviewed did not report having access to post-partum care. Only a few said they had seen a doctor after delivery. Rosemarie complained to Human Rights Watch that she has had pain in her abdomen since the birth. She had been told to return to the doctor, but she was unable to leave the camp to seek care because she did not have money for transport and was afraid to leave her belongings unattended.¹⁶⁵ “The first priority for people living in camps is to defend their space and protect what few belongings they still have,” one medical professional explained.¹⁶⁶

Five women interviewed by Human Rights Watch lost their babies within 24 hours of birth. Of these, none reported having access to postnatal care.

Human Rights Watch found that some women and girls interviewed did have access to traditional birth attendants to assist with delivery. Such attendants live in almost every camp Human Rights Watch visited, and provide elementary care for women and girls. However, access to unskilled birth attendants is insufficient in many cases where an obstetric emergency arises, and in most cases the attendants would be unable to save a woman or infant. Charging up to US\$30, they are often prohibitively expensive for poor women and girls.

Jessie, from a camp in Croix-des-Bouquets, was alone in her tent with her two children when she went into labor. A traditional birth attendant came to assist. For months she has not been able to pay the fee and the birth attendant now visits her tent each day asking for her money.¹⁶⁷

While the government of Haiti has taken steps to ensure obstetric care is economically accessible, additional costs associated with physically accessing care prevent some poor women and girls living in displacement camps from access to care. Of particular concern are adolescent mothers and other high-risk pregnant women left to give birth in the deplorable camp conditions. The UN Population Fund (UNFPA) estimates there has been a 60 percent increase in teenage pregnancies since the earthquake.¹⁶⁸ As Human Rights

¹⁶⁵ Human Rights Watch interview with Rosemarie, camp in Petite-Goave, November 13, 2010.

¹⁶⁶ Human Rights Watch interview with country director, large medical NGO, Port-au-Prince, January 20, 2011. Name withheld upon request.

¹⁶⁷ Human Rights Watch interview with Jessie, camp in Croix-des-Bouquets, January 22, 2011. A traditional birth attendant in Delmas who spoke to Human Rights Watch complained that women who can seek care at hospitals do, and those who cannot go to the hospital seek his services, but cannot pay him. Human Rights Watch interview with Lucien, camp in Delmas 33, November 10, 2010.

¹⁶⁸ GOUDOU GOUDOU: Timoun Boum, pp. 2-3.

Watch has previously noted, adolescent girls are particularly susceptible to obstructed labor, one of the top five causes of maternal mortality worldwide.¹⁶⁹

The government of Haiti has an obligation to protect women's and girls' right to health, which requires it to take measures to prevent women from dying in childbirth in pregnancy, including providing regular and emergency obstetric care.¹⁷⁰ Women and girls facing obstetric emergencies need to be able to reach care to prevent maternal morbidity or death. The government has an obligation to not only make health services economically accessible by providing free care, but should identify and implement measures that it can take to ensure it is economically feasible for the most vulnerable of women and girls to reach the free care.

Obstacles to Quality Care at Medical Facilities

The women and girls who are able to reach a medical facility should be able to obtain obstetric care of good quality. The quality of care is important because it directly affects the health of those seeking care, and poor quality care may influence a woman's decision to seek care in the first place.¹⁷¹ Human Rights Watch found that some women and girls who reached health facilities to deliver are not assured of access to care of a reasonable quality.

While many facilities in the metropolitan area of Port-au-Prince provide free emergency obstetric care, Human Rights Watch interviewed several women and girls who were unaware of this and who went to non-SOG participating hospitals for emergency obstetric care. They encountered difficulties getting treatment because they could not pay for it.

Darline had severe pain during labor, and was transported to a hospital for insured workers for a C-section, but the hospital did not want to admit her because she did not have US\$625 to pay for the operation. The woman's family knew someone who worked at the facility and were able to negotiate a lower price: this did not include any post-operative care.¹⁷²

¹⁶⁹ "I Am Not Dead, But I Am Not Living": Barriers to Fistula Prevention and Treatment in Kenya, pp. 12-13 (citing J. P. Neilson et al., "Obstructed Labour: Reducing Maternal Death and Disability during Pregnancy," *British Medical Bulletin*, vol. 67 (2003), pp. 191-204; Nawal Nour, "An Introduction to Maternal Mortality," *Journal of Obstetrics and Gynecology*, vol. 1, no. 2 (2008), pp. 77-81; and WHO, *Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development* (Geneva: WHO, 2006), p.3.).

¹⁷⁰ See U.N. General Assembly, Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights, A/HRC/14/39, April 16, 2010, at para. 12.

¹⁷¹ See Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/61/338, September 13, 2006, para. 17(d); see also, CRC, art. 24.

¹⁷² Human Rights Watch interview with Darline, camp in Mais Gaté, November 17, 2010.

Yvette was not so fortunate. She had attended prenatal visits as instructed, but the facility did not provide obstetric care, so she had to go to another hospital to give birth. When she went into labor in the evening in a camp near the airport, she did not have money for a taxi, and started walking to a hospital about eight kilometers away, until a friend with a car picked her up. She arrived at the private hospital, but the guard would not let her in. When Yvette was finally admitted, a doctor examined her and could not find the baby's heartbeat; he believed the baby was dead and told her she would need a C-section. She could not pay for the operation, and was asked to leave the hospital. Still in labor, she left the hospital and delivered on the street corner:

It was midnight until 2 a.m., and the baby was born then ... for two hours we were on the corner and I was by myself. I was very afraid, terrified.... [At 2 a.m.] the doctor from [the hospital] cut the umbilical cord for me for US\$50. When they cut the umbilical cord, I didn't have any money to pay.... So he took the car of the friend that brought me to the hospital [until I could pay him back].¹⁷³

The baby was born alive and healthy.

Some women and girls interviewed by Human Rights Watch who did seek free obstetric care in an SOG facility were also not assured quality care. For example, Chancerelles is the largest public maternity ward in the city. Prior to the earthquake, it was severely understaffed and lacked resources.¹⁷⁴ The earthquake destroyed an MSF emergency obstetric hospital in Delmas 33.¹⁷⁵ MSF moved into Chancerelles while its hospital was reconstructed, increasing its capacity and quality of care.¹⁷⁶ Nevertheless, even with the MSF's assistance, Chancerelles did not give every woman high quality care. Martine, 32, said:

I gave birth in Chancerelles, on the ground. I don't have faith in the midwife (traditional birth assistant) and ... so I went to the hospital. All the beds were full so I didn't have any place [to lie down to give birth]. The doctor only cut the umbilical cord and cut the placenta. My husband was there but

¹⁷³ Human Rights Watch interview with Yvette, camp in Mais Gaté, November 10, 2010

¹⁷⁴ Human Rights Watch interview with Nurse Caillot, R.N., chief nurse, Chancerelles Obstetric Hospital, Port-au-Prince, January 26, 2011.

¹⁷⁵ Human Rights Watch interview with Sylvain Groulx, country director, MSF-Holland, Port-au-Prince, January, 2011.

¹⁷⁶ Human Rights Watch interview with Nurse Caillot, R.N., chief nurse, Chancerelles Obstetric Hospital, Port-au-Prince, January 26, 2011.

he didn't see when I gave birth to the baby; they made him sit outside. They didn't put anything on the ground for me. At 10 a.m. I went into labor; I got to the hospital at 1 p.m. I gave birth to the baby at 4:50 p.m..... They sent me home by 10 p.m..... No doctor, nurse, or midwife was there to help with the birth. They only came after to cut the cord.¹⁷⁷

Martine had an infection after the birth that required treatment, which she sought elsewhere.

Impact of Food Insecurity on Reproductive and Maternal Health

Food insecurity in the displacement camps may have an impact on the health of pregnant women and lactating mothers. Human Rights Watch found that food insecurity led some vulnerable women and girls we interviewed to engage in informal transactional sex, compounding the health impact of the lack of access to family planning in camps, and contributing to unintended and unwanted pregnancies.

Food Insecurity for Pregnant and Lactating Mothers

Many pregnant women and girls and lactating mothers told Human Rights Watch that food insecurity was a prime concern. As an underlying determinant of health, pregnant women and lactating mothers have a right to adequate nutrition during pregnancy and lactation.¹⁷⁸

Prior to the earthquake, many women and girls in Haiti struggled to meet their basic needs and those of their children: 23.8 percent of the population was chronically malnourished and 9.1 percent acutely malnourished. People fared better in Port-au-Prince, where the number of malnourished people was half that in rural areas.¹⁷⁹

After the earthquake, international humanitarian organizations rushed to provide emergency food assistance: as many as 4 million people received food assistance in the first six months.¹⁸⁰ General food distribution ended around March 2010, about two months after the earthquake. While targeted food distribution continued for vulnerable populations, including pregnant and lactating mothers and children under the age of 5, it was limited to patients already presenting signs of malnutrition. Generally, for a woman to participate in the food distribution program, her arm circumference would be measured at either a clinic,

¹⁷⁷ Human Rights Watch interview with Martine, camp in Mais Gaté, January 23, 2011.

¹⁷⁸ See, e.g., CEDAW 12(2).

¹⁷⁹ Haiti's Growth and Poverty Reduction Strategy Paper, 2007, p. 54.

¹⁸⁰ IASC, "Haiti Earthquake Response: Six-month Report," July 2010, p. 1.

baby tent, or other place where a woman or girl has access to medical professionals: if this identified that she was possibly malnourished, she was referred to a nutrition facility.¹⁸¹

None of the pregnant women or girls or lactating mothers whom Human Rights Watch interviewed reported receiving food assistance after the end of the general distribution. A systematic survey conducted by the Center for Human Rights & Global Justice (CHRGJ) at New York University School of Law found data that “suggest alarmingly high levels of food insecurity” in the displacement settlements.¹⁸² Almost every woman interviewed by Human Rights Watch raised concerns about their food security. “[I]t's not a good way to live,” said Celine, 19, who lives in a camp in Champ de Mars. “We don't have food, we don't have security.”¹⁸³

For pregnant women and lactating mothers, not having access to food can impact their health. USAID found that hunger and malnutrition were one of the principal maternal and child health issues facing Haiti. Poor nutrition is reflected in the 4 percent of babies born with low birth weight. Moreover, according to USAID, the underlying cause of Haiti's high maternal and neonatal mortality in Haiti is chronic malnutrition.¹⁸⁴

At least three pregnant women and girls interviewed by Human Rights Watch reported feeling extremely weak due to hunger. Claudia, a pregnant adolescent girl, said a doctor had advised her to eat better but that she cannot because her mother, the head of the household, has no job.¹⁸⁵ Tamara told Human Rights Watch, “When I have money, I eat; when I don't, I don't. But, I still try to breast feed the baby.”¹⁸⁶ Another woman, Adeline, reported that her breast milk was not sufficient for her baby, so she had to stop breastfeeding him. For the last three months, she has fed him only cornstarch mixed with water.¹⁸⁷

For women and girls like Tamara and Adeline, adequate nutrition is an important determinant of maternal and infant health. The government has few resources to immediately address the immense gaps in fulfilling the right to food in Haiti. However, it

¹⁸¹ Human Rights Watch interview with Nurse Caillot, R.N., chief obstetric nurse, Chancerelles Obstetric Hospital, Port-au-Prince, January 26, 2011.

¹⁸² Center for Human Rights and Global Justice (CHRGJ), New York University School of Law, “Sexual Violence in Haiti's IDP Camps: Results of a Household Survey,” March 2011, p. 6.

¹⁸³ Human Rights Watch interview with Celine, camp in Champ de Mars, November 14, 2010.

¹⁸⁴ Haiti Maternal and Child Health and Family Planning Portfolio Review and Assessment, p. 7-8.

¹⁸⁵ See Human Rights Watch interview with Claudia, age 16, camp in Mais Gaté, November 17, 2010.

¹⁸⁶ Human Rights Watch interview with Tamara, age 17, camp in Delmas 33, November 10, 2010.

¹⁸⁷ Human Rights Watch interview with Adeline, camp in Croix-des-Bouquets, January 22, 2010

should ensure that food assistance programs are designed, to the fullest extent that resources allow, to address women's and girls' right to health, including maternal health.

Food Insecurity and Increased Vulnerability to Unintended and Unwanted Pregnancy

Human Rights Watch found that food insecurity exacerbated the impact of the lack of access to family planning. Human Rights Watch found evidence that a high number of women and girls we interviewed either formed relationships with men for economic security or engaged in transactional or survival sex without adequate access to methods of contraception that would protect them from unwanted pregnancy.¹⁸⁸

Women have fewer employment opportunities than men, and a higher number are self-employed.¹⁸⁹ Many women and girls told Human Rights Watch they were self-employed prior to the earthquake, mostly through small commerce, but had lost their resources in the quake. These women and girls reported now having no access to income generation. Food insecurity and economic instability led some women and girls we interviewed to engage in risky behaviors, which in turn have an impact on health. The CHRGI survey found evidence that trading sex for basic needs was perceived to have become a more common survival strategy for women and girls living in displacement camps.¹⁹⁰ A UNHCR study on transactional sex among earthquake-affected populations similarly found high levels of transactional and survival sex among women and girls in displacement camps.¹⁹¹ Some women and girls interviewed by Human Rights Watch had become pregnant because of relationships formed for economic reasons or transactional or survival sex. In these cases, the vulnerability that they had sought to address, through improved economic means, only worsened due to the pregnancy.

Margalie, a member of a camp committee in Croix-des-Bouquets, confirmed such relationships exist in her camp:

150 babies have been born in this camp. 83 women are pregnant, some of them are girls, because their parents don't take care of them so they look

¹⁸⁸ Transactional sex is understood as sexual relationships where gifts or services in exchange for sex are a primary factor. Survival sex is the exchange of sex for basic needs, such as food or water.

¹⁸⁹ 83 percent compared to 73 percent for men. See Haiti's Growth and Poverty Reduction Strategy Paper, p. 23.

¹⁹⁰ CHRGI, *Sexual Violence in Haiti's IDP Camps: Results of a Household Survey*, p. 6.

¹⁹¹ UNHCR, "Driven by Desperation: Transactional Sex as a Survival Strategy in Port-au-Prince IDP Camps," May 2011.

for a man to survive ... but the men don't actually take care of them. As soon as they hear the girl is pregnant, they just leave her.¹⁹²

A member of a women's committee in a camp in Mais Gaté noted that unaccompanied adolescent girls in the camp faced unique difficulties:

After the earthquake, all the young girls have adult men under their tent, and now they are pregnant and some give birth under the tent—14, 15, 16 years-old, they are obligated to do this. They don't have parents to take care of them, so if a man can help her, she'll make love and live under his tent.... It's not easy when you are hungry.¹⁹³

The problem is not limited to adolescent girls. Adult women, already mothers, also reported engaging in risky behavior to feed themselves or their children, including trading sex for money. Gheslaine said:

People will try to survive by the way they can. Women have relationships with men so they can feed their children. That happens a lot. My daughter is 12 and does not have friends in the camps, because it happens that even girls are pressured to have sex for things. I don't work. I don't have parents to help. Many times women get pregnant, and they don't have anyone to take care of them. So, for US\$0.60 or \$1.25, you have sex just for that. Unfortunately, women sometimes get pregnant, but if we had access to planning, we'd protect ourselves.... It's not good to make prostitution, but what can you do? You have to eat.¹⁹⁴

Women and girls repeatedly told Human Rights Watch that their partner had left them when they heard they were pregnant, and that they were subsequently left with no access to work or food. Some relied on the informal exchange of sex for food or money, with men who were not their partners, and subsequently became pregnant. In the commercial sex industry in Haiti, men pay higher prices for sex without condoms.¹⁹⁵ In the informal

¹⁹² Human Rights Watch interview with Margalie, camp in Croix-des-Bouquets, January 22, 2011. Margalie was part of a group interview of the camp committee.

¹⁹³ Human Rights Watch interview with Imacola, Barbara, Mona, and Phainord, group interview with women's committee, camp in Mais Gaté, November 10, 2010.

¹⁹⁴ Human Rights Watch interview with Gheslaine, camp in Croix-des-Bouquets, January 22, 2011.

¹⁹⁵ See Human Rights Watch interview with Kettley Alysee, director of Association National de Protection des Femmes et Enfants Haitiens, Port-au-Prince, February 1, 2011.

exchanges of sex for food or money occurring in the camps, women lack the ability to negotiate condom use.

Women and girls who engage in these informal transactions are often desperate and have exhausted other sources of help:

People tell me that I have to stop asking for help, so now I give sex for money, but some of them don't give me money after sex. I have been doing this since I've had the baby. I don't do it very often, but whenever I'm hungry, or for example if I don't have soap to do laundry, I'll do it. When I do, I go far away. For example, when I see an old man I ask him for money, but he usually says "you are too young, too beautiful, but if you have sex, I'll give money...." I do it secretly.¹⁹⁶

Secretly engaging in this behavior exposes women and girls to increased risks of violence, because they lose what little protection may be available to them from social networks or the community.

In preliminary analysis data from its study, CHRGI found that there is a potential correlation between levels of hunger and vulnerability to sexual violence.¹⁹⁷ In its report, UNHCR found a relationship between engaging in survival or transactional sex and increased risk for gender-based violence.¹⁹⁸

Regardless of whether women and girls who exchange sex for food or money are at greater risk for sexual violence, they are at risk of involuntary or unintended pregnancy and sexually transmitted infections, and all the associated health risks. Haiti's government should take measures to design specific interventions that it can take to improve access to services for vulnerable women and girls engaged in informal transactional sex.

Vulnerability to Gender-Based Violence

Women and girls living in camps consistently expressed to Human Rights Watch their concern for their safety and for the security of their possessions. "Sometimes, we have to sleep with one eye open," Rozette, 40, said.¹⁹⁹ Like many women and girls we interviewed,

¹⁹⁶ Human Rights Watch interview with Naomie, camp in Carrefour Feuilles, January 29, 2011, Naomie was raped after the earthquake.

¹⁹⁷ CHRGI, *Sexual Violence in Haiti's IDP Camps: Results of a Household Survey*, p. 6.

¹⁹⁸ UNHCR, "Driven by Desperation: Transactional Sex as a Survival Strategy in Port-au-Prince IDP Camps."

¹⁹⁹ Human Rights Watch interview with Rozette, camp in Delmas 33, November 11, 2010.

she had resigned herself to this feeling. “No, I don’t feel safe really, in the camp,” she added, shaking her head.²⁰⁰

These fears are founded. Human Rights Watch spoke with women and girls who had survived sexual violence in the camp, only to become pregnant from the assault. This has a serious impact on their ability to realize their right to health. The threat of sexual violence is not new. Women and girls faced high levels of gender-based and sexual violence prior to the earthquake.²⁰¹ Some human rights and women’s rights organizations have suggested the number of rapes had increased since the earthquake.²⁰² While statistical data are not available to confirm this, it is clear that women and girls in Haiti remain acutely vulnerable to sexual violence and other forms of gender-based violence.

Human Rights Watch found that women’s and girls’ vulnerability to violence due to low social status, limited protections in the law, and lack of education and livelihood has been compounded by the destruction of their homes, social and familial networks, basic infrastructure, and by limited access to food or livelihood. Some women and girls have lost their small commerce, which gave them financial independence and security. They have lost the security afforded by familial and community relationships, and from having a house with walls and doors that lock. There is no electricity or consistent lighting at night, and some have lost husbands or other family breadwinners. They have no means to feed themselves or their children or to send their children to school.

There is currently no systematic case management or data collection specific to gender-based violence since the earthquake, although the gender-based violence subcluster and the women’s ministry are working towards this. In the absence of such data, NGOs and some UN agencies have attempted to provide a better picture of the rates of sexual violence through small-scale studies or reporting the number of women who have sought treatment at their facilities.

The Small Arms Survey and the University of Michigan found that approximately three percent of its survey sample identified themselves as victims of sexual assault in the first

²⁰⁰ Ibid.

²⁰¹ See Human Rights Watch, *Rape in Haiti: A Weapon of Terror* (New York: July 1994); see also Amnesty International, “Don’t Turn your Back on Girls: Sexual Based Violence Against Girls in Haiti,” November 2008; and S/2009/439, Report of the Secretary-General on the United Nations Stabilization Mission in Haiti 12-13 (September 2009).

²⁰² See, e.g., Institute of Justice and Democracy for Haiti, Bureau des Avocats Internationaux, MADRE, University of Virginia, “Our Bodies Are Still Trembling: Haitian Women’s Fight Against Rape,” July 2010; Amnesty International, “Speak Out: Against Sexual Violence in Haiti’s Camps,” January 2011.

three months after the earthquake.²⁰³ A study of the camp at Parc Jean-Marie Vincent found that 4.1 percent of survey respondents reported that they or someone they knew had been forced to have sex against their will.²⁰⁴ UNFPA's study found approximately 1 percent of women reporting sexual violence, increasing to 1.7 percent in the age range of 20 to 24-year-olds.²⁰⁵ New York University's Center for Human Rights and Global Justice (CHRGJ) conducted a randomized study of four camps and found that nine percent of respondents reported one or more members of their household had been "raped or forced to have sex when they did not want to" in the year since the earthquake.²⁰⁶ Amnesty International has provided compelling qualitative data on the context and conditions of rape in the camps months after the earthquake.²⁰⁷

According to the National Network of Human Rights Defense (RNDDH), the Haitian National Police made 534 arrests in Port-au-Prince related to gender-based violence in the 4 months following the earthquake including: 16 for death threats to women; 9 for rape; 3 for attempted rape; 35 for assaulting a woman; and 2 for attempted murder.²⁰⁸ MSF reported treating 212 patients in connection with sexual violence in the first 5 months after the earthquake.²⁰⁹ Solidarity of Haitian Women (Solidarité Fanm Ayisyen, SOFA) reported treating 718 women and girls for gender-based violence in the 6 months after the earthquake: 114 were victims of rape.²¹⁰ The grassroots group Commission of Women Victims for Victims (KOFAVIV) reports helping 640 victims of rape in the year since the earthquake.²¹¹

Data from these groups also show that gender-based violence impacts women's and girls' reproductive health. SOFA reported that of the 114 sexual assaults it treated from January

²⁰³ Athena R. Kolbe et al., Small Arms Survey & University of Michigan, "Assessing Needs After the Quake: Preliminary Findings from a Randomized Survey of Port-au-Prince Households," 2010, p. 23.

²⁰⁴ Kimberly A. Cullen and Louise C. Ivers, "Human rights assessment in Parc Jean Marie Vincent, Port-au-Prince, Haiti," *Health and Human Rights: An International Journal*, vol. 12, no. 2 (2010), p. 1214.

²⁰⁵ See GOUDOUGOUDOU: Timoun Boum, pp. 2-3.

²⁰⁶ Sexual Violence in Haiti's IDP Camps: Results of a Household Survey, p. 3.

²⁰⁷ See generally "Speak Out: Against Sexual Violence in Haiti's Camps."

²⁰⁸ National Network of Human Rights Defense (RNDDH), "The general situation of the country four months after the earthquake of January 12, 2010," May 12, 2010, p. 18.

²⁰⁹ Doctors Without Borders/ Médecins Sans Frontières (MSF), "EMERGENCY RESPONSE AFTER THE HAITI EARTHQUAKE: CHOICES, OBSTACLES, ACTIVITIES AND FINANCE," July 2010, six months after the earthquake on January 12. Covers the reporting period up to May 31, p. 18.

²¹⁰ SOFA, "Rapport Bilan 10, Cas de Violences Accueillies et Accompagnées dans Les 21 Centres Douvanjou de la SOFA de Janvier a Juin," 2010, p. 5.

²¹¹ MADRE, CUNY School of Law, IJDH/BAI, "Our Bodies Are Still Trembling: Haitian Women Continue to Fight Against Rape," January 2011, p. 6.

to June 2010, 6.36 percent resulted in pregnancy.²¹² The grassroots group, Centre d'Appui pour les Femmes Victimes d'Abus Sexuels (CAFVAS), reported that of the 45 rapes it recorded from February to March 2010, 9—a full 20 percent—resulted in pregnancy.²¹³

Six of the women and girls whom Human Rights Watch interviewed were pregnant because of rape that occurred after the earthquake. Three of these were adolescent girls, aged between 14 and 15. This suggests that women and girls do not have access to the reproductive and sexual health services they need after they have been victims of sexual violence, namely access to emergency contraceptive and prophylaxis for STIs, including HIV. Some women's groups told Human Rights Watch that emergency contraception and other post-rape care were sometimes unavailable at medical facilities designated as referral facilities for victims of sexual violence. Human Rights Watch found in its interviews that women and girls failed to access timely post-rape care because they did not know what to do or where to go for treatment, or they were ashamed to report the rape.

Prior to the earthquake, a study found that 26 percent of women who experienced sexual violence in Haiti reported that they had sought assistance from their own relatives. According to the study, victims identified mothers as the single most important source of help, followed by friends and neighbors. In contrast, only two percent of survivors of sexual violence reported seeking assistance from the police, a lawyer, or a doctor.²¹⁴ The earthquake destroyed the social network of many women and girls, including family connections, neighbors, schools, churches, and local clinics, disrupting the ability of women and girls to seek assistance after experiencing sexual violence.

Women and girls interviewed reported that they were reluctant to seek timely medical care after a rape because they were shy or ashamed. Mary Loudy, 15, waited eight days before telling an adolescent cousin about a sexual assault.

After eight days, I talked to my cousin about it because she had been raped also after the earthquake. She advised me to go to GHESKIO (the acronym for the Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections) Center. I had an infection. Before I talked to her about my rape, I

²¹² Rapport Bilan 10, p. 10.

²¹³ Human Rights Watch interview with Elliot Kedar Hugguens, Centre d'Appui pour les Femmes Victimes d'Abus Sexuels (CAFVAS), Port-au-Prince, January 25, 2011 ; see also, Human Rights Watch interview with Elliot, Centre d'Appui pour les Femmes Victimes d'Abus Sexuels (CAFVAS), Port-au-Prince, March 10, 2011.

²¹⁴ Contreras, J. M.; Bott, S.; Guedes, A.; Dartnall, E., Sexual Violence Research Institute, "Sexual violence in Latin America and the Caribbean: A desk review," March 2010, pp. 37-38.

was really shy but I told myself that she was raped so I can talk to her about my situation.²¹⁵

The delay meant she did not receive timely medical care and faced an unwanted pregnancy. Mary Loudy's cousin is 17 and remains in the same camp where she suffered the rape.

Naomi, 25, had a relationship with a man who raped her. After the rape, he gave her payment. Naomi went to the hospital and the police, but became pregnant. After she gave birth, the man who raped her wanted to take the baby away from her. She refused and the man came to her tent one night with his several of his friends. Each of the men raped Naomi. After that, she was too ashamed to seek post-rape care.

I went to the hospital and police after the first rape, but not after the second one because.... I feel ashamed to repeat rape. I have been to the hospital since because I had appointment for planning. I didn't tell them I had been raped, because I was ashamed.²¹⁶

When Naomi attended an appointment for family planning after she had been raped, the attending medical professional did not recognize that she might have been a victim of violence. She sought no care for her second rape.

Human Rights Watch found that women and girls it interviewed with pregnancies caused by rape face the same difficulties accessing maternal care as other women interviewed, with similar impacts on these women's health or the health of their children. Florence is barely 15-years-old, is 5 months pregnant, and has no parents. She lived with a family and did domestic chores for them. After the earthquake, she and the family moved to a camp in Mais Gaté. Her employer raped her, then threatened her and told her not to tell anyone. She became pregnant, and someone in the camp took her to one prenatal appointment. Florence discontinued prenatal care because she could not afford ancillary tests.

I went one time to the doctor who gave me a prescription. I don't have money to get the blood test and stool sample. The doctor said to come back, but he advised me to come back with the test results.... I don't have a

²¹⁵ Human Rights Watch interview with Mary Loudy, 15, camp in Carrefour Feuilles, January 29, 2011.

²¹⁶ Human Rights Watch interview with Naomi, camp in Carrefour Feuilles, January 29, 2011.

mother or father, I live with an “aunt,” but she doesn't take care of me now. Now I live in the camp with someone else, since I was raped.²¹⁷

Florence is a high-risk pregnancy because of her age and small size, and she has no access to care.

Human Rights Watch does not have evidence to draw a direct connection between rape and poor maternal and infant health. However, the acute vulnerability of women and girls who become pregnant as a result of rape means that even those with access to health care appear to face grim prospects in pregnancy and child birth. One woman had a stillbirth. Another, Mary Loudy, lost her baby within 24 hours of delivery—and she had better access to care than other women and girls Human Rights Watch interviewed: prenatal care, and a free sonogram that a private technician offered her because of her situation. When Mary Loudy went into labor, she went to an NGO clinic where it was determined she needed emergency obstetric care. It transported her free of cost to the general hospital, then to Chancerelles, where she received the care she needed for free. She gave birth and was sent home with the baby, who appeared fine but died shortly after she returned to the camp.²¹⁸

Sexual violence is a violation of the right to physical integrity and the right to health. Inherent to the right to sexual and reproductive health is the right to control one's health and body.²¹⁹ Rape and other forms of sexual violence represent a “serious [breach] of sexual and reproductive freedoms, and are fundamentally and inherently inconsistent with the right to health.”²²⁰ The Haitian government has an obligation to “take steps to prevent third parties from jeopardizing the sexual and reproductive health of others, including through sexual violence.”²²¹ Moreover, it has the obligation to prevent, investigate, sanction and provide reparations for human rights violations.²²²

²¹⁷ Human Rights Watch interview with Florence, camp in Mais Gaté, November 9, 2010.

²¹⁸ Human Rights Watch interview with Mary Loudy, 15, Carrefour Feuilles, January 29, 2011.

²¹⁹ Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/61/338, September 13, 2006, para. 25

²²⁰ *Ibid.*

²²¹ Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, February 2004, E/CN.4/2004/49, para 44.

²²² See IACHR, “The Right of Women in Haiti to be Free from Violence and Discrimination,” March 10, 2009, para. 81, citing I/A Court H.R., Velásquez Rodríguez Case. Judgment of July 29, 1988. Series C No. 4; article 6 of the Inter-American Convention against Torture; and article 7(b) of the Convention of Belém do Pará. CEDAW also imposes an obligation on Haiti to show due diligence in preventing and responding to human rights violations.

Even though acts of gender-based violence may be perpetrated by private actors, Haiti has obligations to eliminate discrimination against women and girls, including by private actors.²²³ The CEDAW Committee stated in General Recommendation 19 that “states may [...] be responsible for private acts if they fail to act with due diligence to prevent violations of rights or to investigation and punish acts of violence.”²²⁴ Accordingly, Haiti must “apply due diligence to prevent, investigate and impose penalties for violence against women” and must take special account of the vulnerability of displaced women and girls.²²⁵ This obligation extends to both acts perpetrated by its own agents and those by non-state actors and private parties, if under the state’s tolerance or acquiescence.²²⁶

This does not change in a post-disaster setting, as the Minimal Initial Service Package for Reproductive Health in Crisis Situation makes clear that the state is required to prevent and respond to sexual violence in post-disaster settings.²²⁷

Lack of Accountability in Addressing Women’s and Girls’ Health and Security in Displacement Camps

We have no information. Nothing. I would like to know what will happen to us.

—Vyola, resident of a camp in Delmas 33, November 11, 2010

We are ready to move on, but we don’t know how they [the government and NGOs] will get us into this process.

—Claudine, resident of a camp in Cite Soleil, January 31, 2011

Many NGOs, donors, and experts on maternal health have sought to address the needs of women and girls in post-earthquake Haiti. Most notably, Human Rights Watch found that the Free Obstetric Care project (SOG) allowed many women and girls access to care they previously could not afford. Yet for many women and girls Human Rights Watch interviewed

²²³ UN Committee on the Elimination of Discrimination against Women, General Recommendation 19, Violence against Women, (Eleventh session, 1992), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, UN Doc. HRI\GEN\1\Rev.1 (1994), p. 84, para. 9. The CRC also obliges the government to prevent discrimination of any kind against girls. CRC, art. 2.1.

²²⁴ UN Committee on the Elimination of Discrimination against Women, General Recommendation 19, Violence against Women, (Eleventh session, 1992), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, UN Doc. HRI\GEN\1\Rev.1 (1994), p. 84, para. 9.

²²⁵ Convention of Belém do Pará, arts. 7(b), 9.

²²⁶ The Right of Women in Haiti to be Free from Violence and Discrimination, para. 86, citing I/A Court H.R., Case of the “Mapiripán Massacre.” Judgment of September 15, 2005. Series C No. 134, para. 178.

²²⁷ The Long Wait: Reproductive Health Care in Haiti, p. 11 (citing Sphere Humanitarian Charter and Minimum Standards in Disaster Response).

access to reproductive and maternal care is a matter of luck: for example, whether or not they fall within the catchment area of a public facility participating in SOG, or a successful NGO; and whether they even learn of the services available.

The lack of information among women and girls interviewed by Human Rights Watch in the displacement camps pervaded all aspects of their lives and impacted the realization of a wide range of rights. Women and girls reported to Human Rights Watch that they generally had no information about what medical services were available nearby, or for what price. They also knew nothing of the specific health plans for the camps where they lived, or for the country as a whole. Moreover, Human Rights Watch found many women and girls we interviewed lacked access to basic information necessary to seek accountability, including which NGOs operated in the camps where they lived, what services they provided, and who to speak to if there was a problem. They also lacked the information necessary to report or seek redress for problems related to maternal or reproductive health services.

The government, which should be exercising oversight in the provision of maternal health care, does not have current and comprehensive maternal health data for women and girls living in camps who do not reach one of its facilities for care. Nor does it have data on women and girls who discontinue care. Without that information, it is not possible to identify and implement measures to develop redress mechanisms for mistakes or grievances, to correct systemic failures, or to replicate effective programs.²²⁸

Human Rights Watch found that important information that is necessary for the Haitian government to monitor progress related to maternal health is not recorded in camps: for example, none of the five infant deaths recounted by women and girls interviewed by Human Rights Watch were reported or registered with any NGO or government body. Camp residents told Human Rights Watch that deaths in the camp, regardless of cause, generally went unregistered. Thus, if women and girls die of maternal-related deaths in the camps, they would not be recorded. This basic data on maternal and infant deaths is fundamental to determining whether the government is making progress on its obligations related to the right to health.

The lack of accountability mechanisms, either through grievance systems or other avenues for providing feedback to actors operating in the camps, impacts other rights as well. For example, United Nations Stabilization Mission in Haiti (MINUSTAH), UNPOL, and Haitian

²²⁸ Human Rights Watch, *No Tally of the Anguish: Accountability in Maternal Health Care in India* (New York: 2009), pp. 115-124, citing Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, August 2008, A/63/263, para. 8.

National Police (HNP) began regular patrols of certain camps at high-risk for gender-based violence. Women and girls interviewed by Human Rights Watch in some of these camps reported a degree of improvement in the security situation and were grateful for the patrols; others said the patrols had become too predictable. “[Thugs] know the hours of patrols,” said Ani.²²⁹ These women and girls did not know how to report this concern.

NGOs and UN agencies also installed lights to prevent gender-based violence in the camps. A resident in one camp reported that despite initial gains made after the lights appeared, the NGO that supplied them soon ran out of funding to purchase the fuel needed to power them. Three rapes occurred in the first four weeks after lighting in the camp was no longer available.²³⁰ Yet women’s groups in the camp knew of no avenue for seeking redress or assistance for this loss of security.

Human Rights Watch found that for many women and girls we interviewed lack of access to information is a considerable barrier to the enjoyment of their maternal health rights. Better coordination and linking of sources of information would give the government of Haiti tools to ensure women and girls have current and reliable information related to their rights. Human Rights Watch also found that data was lacking that would allow for monitoring the implementation of rights.

Statistical systems would allow for the monitoring of progress towards the realization of certain rights, including progress related to maternal health. Moreover, planning, monitoring, and country-led evaluations would provide data necessary for the government to correct systemic failures and replicate programs that work, in line with the human rights principle of accountability.

²²⁹ Human Rights Watch interview with Ani, camp in Martissant, January 29, 2011.

²³⁰ Human Rights Watch interview with Fritznel, male member of women’s group in camp in Port-au-Prince, January 27, 2011.

III. Donor States and Non-State Actors in Haiti

The Haitian government is the primary guarantor of human rights in Haiti. Even in the aftermath of a disaster and facing the limitations on resources that it does, it must take steps to respect and protect the core minimum content of the rights of women and girls. However, to demand that the government alone address the obstacles to the fulfillment of these rights would be to ignore the political and economic realities that the country faces.

In compliance with their international obligations, states should respect the enjoyment of the right to health in other countries and prevent third parties, through political or legal means, from interfering with the enjoyment of the right.²³¹ In furtherance of this obligation, both the Committee on Economic, Social and Cultural Rights (CESCR) and the UN special rapporteur on the right to health have observed that, “States should ensure that their actions as members of international organizations take due account of the right to health.”²³² The CESCR also has determined that “international assistance and cooperation, especially economic and technical” should enable developing countries to fulfill their core and other obligations.²³³ The UN special rapporteur has indicated that states should pay particular attention to helping other states achieve minimum essential levels of health.²³⁴

NGOs, when operating as non-state actors, do not bear the same international obligations under human rights law as governments do.²³⁵ However, they do not function in a human rights void and should operate in a manner that promotes human rights.²³⁶ United Nations human rights bodies have urged all actors to adopt a rights-based approach to their work.

²³¹ See for example, General Comment 14, para. 39.

²³² Ibid., para. 39; Report of the UNSR on health, February 2004, para. 46.

²³³ Ibid., para. 45.

²³⁴ Report of the UNSR on health, February 2004, para. 46.

²³⁵ The humanitarian community has industry standards to which many organizations have pledged themselves, including the Sphere Project Standards. The Minimal Initial Service Package (MISP) for Reproductive Health are derived from these standards and set targets for provision of reproductive health services in emergency settings. See Sphere, Humanitarian Charter and Minimum Standards in Disaster Response and the Inter-agency Standing Committee Health Cluster Guide. The MISP includes: the prevention of sexual violence and provision of post-rape care; protection against HIV transmission; emergency care for pregnant women and newborns; provision of contraceptives, antiretrovirals and care for sexually transmitted infections (STIs). While family planning is not a component of the MISP in the emergency phase of a crisis, it is an essential component of comprehensive reproductive health services that should be established when the emergency phase has stabilized.

²³⁶ See, e.g., standards addressed inter alia to NGOs, including Guiding Principles on Internal Displacement, U.N. Doc. E/CN.4/1998/53/Add.2 (1998),¹¹ February 1998, and Recommended Principles and Guidelines on Human Rights and Human Trafficking, E/2002/68/Add.1, May 20, 2002. The evolving status of NGOs and human rights responsibilities has been the subject of significant study, see, e.g., Andrew Clapham, *Human Rights Obligations of Non-State Actors* (Oxford: Oxford University Press, 2006).

In Haiti, the UN Independent Expert on Human Rights in Haiti has recommended that “the role of human rights in the various phases of humanitarian work should ... be reasserted and strengthened.”

A rights-based approach draws upon the principles and legal framework of human rights, and requires that respect for the human rights of those affected by any aid or development activity is central to planning and operationalizing that activity. It recognizes beneficiaries of aid as rights-holders with legal entitlements and identifies governments and their partners as duty-bearers with correlating obligations to meet those entitlements. A rights-based approach requires particular attention to the needs of vulnerable groups, the impact of programs on their rights, and the establishment of procedures to ensure accountability and participation in an organization’s operations. It also requires that human rights standards guide all stages of programming.²³⁷

Human Rights Watch researched whether certain human rights standards related to women’s and girls’ right to health were met in the camps. While the Haitian government has the correlative obligation related to the rights at issue, it relies on support from the donor community to fulfill its obligations.

Reproductive and Maternal Health

The government of Haiti developed a post-disaster needs assessment (referred to as the PDNA) and national plan for recovery to address the needs of the population after the earthquake, including women’s and girls’ health and security. The national plan for recovery “[concentrates] on the improvement in access to and quality of primary healthcare, with an emphasis on high-impact, low-cost actions targeting maternal and infant health...”²³⁸

The needs assessment determined steps should be taken to “develop services in maternal and reproductive health and to combat the spread of HIV/AIDS,” to “integrate the protocols and inputs required for providing medical care for women and girls who are victims of violence,” and to “respond to women’s special health needs and provide appropriate local

²³⁷ Office of the United Nations High Commissioner for Human Rights, “Frequently Asked Questions on a Rights-Based Approach to Development Cooperation,” 2006, p. 35, <http://www.ohchr.org/Documents/Publications/FAQen.pdf> (accessed July 31, 2011), citing *The Human Rights Based Approach to Development Cooperation Towards a Common Understanding Among U.N. Agencies: Attachment 1 to Report of The Second Interagency Workshop on Implementing a Human Rights-Based Approach in the Context of U.N. Reform* (2003).

²³⁸ Government of Haiti, “Action Plan for National Recovery and Development of Haiti,” March 2010, p. 37.

services.”²³⁹ Not having sufficient funds of its own, the Haitian government is dependent upon donors, international organizations, and NGOs to fund and implement its plan.

Donors pledged funds for the humanitarian or emergency phase through the February 2010 Humanitarian Appeal for Haiti, and coordinated through the UN’s Office for the Coordination of Humanitarian Affairs (OCHA).²⁴⁰ This appeal was renewed in November 2010, with the 2011 Consolidated Appeals, which included appeals for the cholera epidemic. In response to the needs assessment and national plan for recovery, donors pledged funds for reconstruction at the March 31, 2010 Donor’s Conference—in line with the Haitian government’s priorities. Pledges and projects are coordinated through the Interim Haiti Recovery Commission (IHRC), which was established by then-President Preval and includes representatives from Haiti and donor countries.²⁴¹

In the past, donors were reluctant to support the government directly and coordinate with it because it lacked a plan, but after the earthquake the Ministry of Health (MSPP) elaborated upon the findings of the needs assessment and the national plan for recovery and designed an interim and comprehensive plan for the health sector.²⁴² This included goals for the sector over 18 months, and identified maternal health as a priority.²⁴³ The government envisaged a network of NGO-run mobile clinics, and referral institutions to provide uninterrupted health care to persons living in displacement camps in the first six months. It then called for a transition to fixed clinics, with an increase overall in access to primary care. After six months, the recovery phase began to wind down, and the focus turned to developing more permanent infrastructure and services, located outside the camps.

The plan gave the Haitian government an opportunity to work towards fulfilling its obligations with regard to maternal and reproductive health in the long-term.²⁴⁴ In an effort

²³⁹ Government of Haiti, “Haiti Earthquake PDNA: Assessment of damage, losses, general and sectoral needs: Annex to the Action Plan for National Recovery and Development of Haiti,” March 2010, p. 13.

²⁴⁰ OCHA, Haiti Revised Humanitarian Appeal, p. 15.

²⁴¹ The mandate of the IHRC is to oversee billions of dollars in reconstruction aid and to conduct strategic planning and coordination among multi-lateral and bilateral donors, non-governmental organizations and the private sector. Funded projects are submitted to the IHRC for approval, which issues its decision in accordance with the government’s reconstruction plan.

²⁴² Human Rights Watch interview with Dr. Claude Surena, coordinator of Haiti National Commission to Reconstruct the Health System, Port-au-Prince, February 2, 2011; see also Plan Interiminaire du Secteur Santé, pp.19-22.

²⁴³ Ibid.

²⁴⁴ Government of Haiti, Action Plan for National Recovery and Development of Haiti, p. 37. In the short-term, the government’s plan to address maternal health in the camps in the six months after the quake was through both fixed clinics and mobile brigades. The mobile brigades would serve those camps with less than 5,000 inhabitants, while the fixed clinics, which could be just a tent, would service the camps with more than 5,000 inhabitants. According to the plan, mobile brigades would be equipped with birthing and rape kits and provide prenatal and post-partum care. Fixed clinics also would

to execute funding according to the plan, government representatives sat down with donors and NGOs and shared information about the plan and the budget.²⁴⁵ Yet according to some people working with the government there was “still a tendency for NGOs and donors to do things their way.”²⁴⁶ For example, the government, as a member of the health cluster, tried to coordinate the arrival of new medical NGOs. It established an online registration form, and has over 400 registered medical NGOs. It also created reporting guidelines for NGOs; however, as of February 2011, of these 400 registered NGOs, only 14 had filed reports with the health ministry as requested.²⁴⁷ In August 2011, that number had increased, although specific numbers could not be given to Human Rights Watch. The Ministry of Planning, however, has a separate reporting requirement for NGOs. By June 2011, 169 NGOs had submitted reports for fiscal year 2008-2009 and 2009-2010, in compliance with the ministry’s requirements.

With no compliance mechanism in place, the Haitian government depends on NGOs to provide it with information about their activities in order to assess what progress has been made on the plan.²⁴⁸ This is made more difficult by the sheer number of actors operating in Haiti. There is currently no accurate information on how many NGOs operate in Haiti, although estimates ranged from 3,000 to 10,000 even before the earthquake. In 2009 the United Nations special envoy to Haiti, former President Bill Clinton, said that Haiti had the second highest number of NGOs per capita in the world.²⁴⁹

Some NGOs already engage in monitoring and evaluation of the impact of their work. PSI (Population Services International), for example, focuses on the measurable outcomes of its family planning education work and shares this information with the ministry of health and with the reproductive health subcluster. “The value of our approach is that we know if we succeed, if things get better,” says Dr. Mardel Sherley David, director of family planning

also have gynecology kits and be staffed with a nurse-midwife or an OB/GYN. The camp and mobile clinics would be part of a referral network for patients requiring more specialized care.

²⁴⁵ OCHA also implemented the cluster system in Haiti after the earthquake. A large number of NGOs and UN agencies participated in the health cluster. So many organizations attended meetings that a decision was made to create a smaller core cluster of the health NGOs with more experience in Haiti. The health cluster was also crucial in the execution of the 2010-2011 cholera response.

²⁴⁶ Human Rights Watch interview with Dr. Claude Surena, Port-au-Prince, February 2, 2011. For example, when the health ministry (MSPP) developed specific procedures to train cholera outreach workers, a large NGO created its own. The MSPP could not impose its procedures on the NGO, because the government has no control over the money that supports the NGO.

²⁴⁷ Ibid.

²⁴⁸ Ibid.

²⁴⁹ See, United States Institute of Peace, “Peace Brief: Haiti: A Republic of NGOs?,” April 26, 2010, citing Trenton Daniel, “Bill Clinton Tells Diaspora: ‘Haiti Needs You Now,’” Miami Herald, August 10, 2009.

at PSI.²⁵⁰ The SOG project has also conducted considerable evaluation of patient satisfaction in participating facilities. Not all NGOs or donor-funded projects, however, are equipped for the rigorous monitoring and evaluation of their work. And, the sharing of data and reporting that is done in Haiti is sometimes limited. “I wasn’t prepared for how difficult it would be to get information. No one is sharing data. No one is evaluating their impact and then changing what they do. If they are, I don’t see the reporting, the results,” one United Nations agency staff member working to coordinate health efforts told Human Rights Watch.²⁵¹

There are various reasons why some NGOs are not sharing data with the government or each other. Some NGOs with better performance indicators do not want their data to be aggregated and reported alongside data from less efficient or effective operations, as this may hide others’ poor performance and skew the overall picture. For example, one NGO representative self-identifying as one of the more effective groups told Human Rights Watch it was reluctant to share certain types of data. “The fact that we mobilized quickly in recovery efforts should not be seen as a reflection of successful donor-led recovery, but of our own efficiency.”²⁵² By contrast, some NGOs undoubtedly do not want to advertise their ineffectiveness or inefficiencies. Also, the government has not created easy and centralized avenues for reporting, making it confusing and time-consuming for NGOs to comply with all reporting requirements, guidelines, and requests. The government is working to create a better streamlined mechanism for such reporting, and initial feedback from NGOs is that they would more readily comply with reporting guidelines if this occurred.

Whatever the reason, the paucity of data transmitted to the government makes it difficult for the state and human rights monitors to assess progress on the implementation of the health plan and its impact on the realization of rights. It is even more difficult to know who to blame when progress stalls.

Despite some successes, there is evidence that some NGOs and donors may not have followed through on their plans. The WHO and Pan American Health Organization reported that many camps did not have health care services nine months after the earthquake, and that in some cases mobile clinics were nothing more than a tent with a box.²⁵³ In one camp

²⁵⁰ Human Rights Watch interview with Dr. Mardel Sherley David, director of family planning, Population Services International, Pétion-ville, February 3, 2011.

²⁵¹ Human Rights Watch interview with United Nations agency staff, Port-au-Prince, January 31, 2011.

²⁵² Human Rights Watch interview with country director, large medical NGO, Port-au-Prince, January 20, 2011. Name withheld upon request.

²⁵³ PAHO, “Situation Update: Nine Months After the Earthquake in Haiti,” October 2010, p. 4.

in Delmas 33, Human Rights Watch sat with camp residents in an empty, humid tent; some brought broken chairs from their own tents to provide us with a place to sit and discuss camp conditions. Edzer, a camp committee member, complained that the NGOs “set up this tent, but there is no clinic. The doctors are the flies you see.”²⁵⁴ Indeed, Human Rights Watch visited several camps with empty tents that had at one point been designated as a clinic, but which camp residents claim never fulfilled that role.

The Haitian government does not have the capacity to go into the field to see if NGOs provide the services they claim to, if there are gaps in services, or if NGOs are duplicating their work. The government does not know if there is an impact on the fulfillment of rights from all of the aid. In other words, there is no accountability regarding outcomes. Without donors and NGOs, Haiti would, according to one government official, be “in big trouble,” but there needs to be “stronger government engagement ... [with] a structure and regulations to ensure that the proper things are done in the appropriate ways.”²⁵⁵

Coordination must go both ways, however, and some NGOs argue that the government needs to rise to meet the challenges it faces and act like a leader in the recovery process, which would include making difficult decisions about strategy and resource allocation and assuming responsibility for the outcomes.²⁵⁶ Admittedly, this is difficult when well over 50 percent of the government’s budget comes from donors.²⁵⁷ Moreover, coordination with the government is also difficult when ministries lack new appointees to lead. This will not abate until the political stalemate between President Martelly and the Parliament ends and a Prime Minister and full government are appointed and confirmed.

Yet donors and recipient countries have recognized a shared interest in accountability in the effectiveness and use of aid.²⁵⁸ The aid that donor countries and international agencies give is subject to the principles set out in the 2005 Paris Declaration on Aid Effectiveness, supplemented by the 2008 Accra Agenda for Action.²⁵⁹ Haiti and most of its key funding agencies and donor countries adhere to the Paris Declaration and the Accra Agenda for

²⁵⁴ Human Rights Watch interview with Edzer, camp committee member, camp in Delmas 33, November 7, 2010.

²⁵⁵ Human Rights Watch interview with Dr. Claude Surena, Port-au-Prince, February 2, 2011.

²⁵⁶ Human Rights Watch interview with country director, large medical NGO, Port-au-Prince, January 20, 2011. Name withheld upon request.

²⁵⁷ *Ibid.*

²⁵⁸ See, Paris Declaration on Aid Effectiveness, <https://www.oecd.org/dataoecd/11/41/34428351.pdf>. For a more detailed discussion of mutual accountability between donor and recipient countries, see No Tally of the Anguish: Accountability in Maternal Health Care in India, pp. 124-26.

²⁵⁹ Paris Declaration on Aid Effectiveness, <http://www.oecd.org/dataoecd/11/41/34428351.pdf> (accessed July 18, 2011).

Action.²⁶⁰ Under the declaration, based on the principle of mutual accountability between donor and partner (recipient) countries, donors have committed to aligning their overall support—including country strategies, policy dialogues, and development cooperation programs—with partners’ national development strategies and periodic reviews.²⁶¹ In Haiti, that means donors should provide aid in line with the national recovery plan.²⁶²

The declaration recognizes the “shared interest” of donors and partners “in being able to monitor progress.” To this end, recipient countries and donors should “establish mutually agreed frameworks that provide reliable assessments of performance, transparency and accountability of country systems.” In keeping with the principle of mutual accountability, donors have also undertaken to “provide timely, transparent and comprehensive information on aid flows.”²⁶³

In the Accra Agenda for Action, donor states and institutions reiterated a commitment to accountability, but agreed to be held accountable before their “respective parliaments and governing bodies for these outcomes.”²⁶⁴ Recognizing that “greater transparency and accountability for the use of development resources—domestic as well as external—are powerful drivers of progress,” they committed to taking several measures to further such transparency and accountability.²⁶⁵ These include the commitment of developing countries and donors to “assess the impact of development policies and adjust them as necessary,” through better coordination and linking of sources of information, statistical systems, planning, monitoring, and country-led evaluations of performance.²⁶⁶ To this end, donors committed to supporting and investing in the statistical capacity and information systems of developing countries.²⁶⁷

²⁶⁰ For a list of countries and organizations that have adhered to the Paris Declaration, see “Countries, Territories, and Organizations Adhering to the Paris Declaration,” http://www.oecd.org/document/22/0,3746,en_2649_3236398_36074966_1_1_1_1,00.html (accessed July 18, 2011).

²⁶¹ Paris Declaration, para. 16.

²⁶² The Office of the United Nations Special Envoy for Haiti does work to monitor the disbursement of donor pledges, including to what type of institution the money has been disbursed to and the progress on fulfillment of pledges. It also has monitored the percentage of funds that have flown through the Interim Haiti Reconstruction Commission (IHRC) and are part of the government’s recovery plan. The IHRC was established to ensure coordination between donors and the government. The office found that 53 percent of aid after the earthquake has been channeled to projects started prior to the earthquake and 64 percent has been channeled to projects not approved by the IHRC. See Office of the Special Envoy for Haiti, “Has Aid Changed? Channelling assistance to Haiti before and after the earthquake,” June 2011, p. 18.

²⁶³ *Ibid.*, para. 49.

²⁶⁴ Accra Agenda for Action, Third High Level Forum on Aid Effectiveness, Ghana, September 2-4, 2008, <http://www.oecd.org/dataoecd/58/16/41202012.pdf> (accessed June 23, 2009), para. 10.

²⁶⁵ *Ibid.*, para. 22.

²⁶⁶ *Ibid.*, para. 23(b).

²⁶⁷ *Ibid.*, para. 23(c).

Donors and the government of Haiti should commit to all components of mutual accountability related to recovery and reconstruction aid. Such accountability should provide the government with tools to be accountable to its citizens and rights-holders, including data that would allow for monitoring progress towards the realization of its reconstruction goals and the rights of its citizens. It would allow the government to ensure that individuals have current and reliable information related to their rights. Weak accountability between the government and donors (and donor-funded NGOs) may lead to weak accountability for rights-holders.

Gender-Based Violence

The role of non-state actors regarding gender-based violence is more straightforward, as several non-state actors have clear protection mandates. For example, the UN Stabilization Mission in Haiti, MINUSTAH, is specifically charged with working with the government as a partner to prevent gender-based violence.²⁶⁸ The government specifically identified the need to “ensure the security of women and young girls in the camps and undertake measures to reduce violence against women” in its post-disaster needs assessment.²⁶⁹ It called upon the Haiti National Police to promote protection of women against sexual violence and to “[strengthen] the synergies with other partners involved in taking care of victims of violence.”²⁷⁰ The needs assessment also called on the health system to “integrate the protocols and inputs required for providing medical care for women and girls who are victims of violence.”²⁷¹ However, it had little practical control at the start of the emergency over how the humanitarian response addressed the security of women and girls.²⁷²

²⁶⁸ See, Security Council Resolution 1927, S/RES/1927 (2010).

²⁶⁹ Government of Haiti, Haiti Earthquake PDNA: Assessment of damage, losses, general and sectoral needs: Annex to the Action Plan for National Recovery and Development of Haiti (March 2010), pp. 17, 38.

²⁷⁰ *Ibid.*, p. 10.

²⁷¹ *Ibid.*, p. 13.

²⁷² Gender-based violence (GBV) was incorporated in the OCHA cluster system from the beginning of the disaster response. The GBV subcluster was included in the protection response to coordinate GBV actors in humanitarian organizations, women’s rights organizations and UN agencies. As early as February 2010, Human Rights Watch researchers noted with concern reports of gender and sexual-based violence. Nevertheless, GBV concerns were not adequately addressed early in the emergency phase: few organizations had GBV specialists to incorporate protection concerns into distribution plans; bathing and toilet facilities were not separated by gender; and there was a lack of lighting throughout camps. Slowly the subcluster and its members began to address protection concerns. But, disputes among women’s rights groups regarding the work of the subcluster plagued efforts to address the continued high levels of GBV. Though instituted immediately after the earthquake, resources were slow in reaching the subcluster. See InterAction, “Policy Paper: Lessons from the Haiti Response and Recommended Next Steps: An Analysis from InterAction’s Gender-Based Violence Working Group,” November 2010, p. 2. There was also high staff turnover in the beginning, and no consistent voice advocating for funding of the subcluster. Furthermore, the GBV subcluster seemed to struggle to understand the context of GBV prior to the earthquake and the importance of the work of Haitian women’s rights groups, UNIFEM, and the Haitian government in addressing this context. Moreover, some groups argue that rather than play a coordinating role between humanitarian organizations, the women’s ministry, and local women’s groups, the GBV subcluster repeated patterns of exclusion that occurred prior to the earthquake.

Women's rights and human rights groups, including Human Rights Watch, began to report cases of sexual violence early in the recovery period. Some groups frustrated by what they believed was a lack of response by the authorities in Haiti, brought a petition for precautionary measures before the Inter-American Commission for Human Rights.²⁷³ Since then, some progress has been made in preventing sexual violence in camps. For example, increased patrolling by UN soldiers and the Haitian police has led in some places to a fall in the number of cases.²⁷⁴ In one camp with a MINUSTAH post, women will sleep in front of the UN soldiers for added security if violence becomes too active.²⁷⁵ Lighting has been installed in some camps, which has given women some additional security.²⁷⁶

Yet 18 months after the earthquake, the Haitian government and the UN have failed to produce data on the scale of the problem, without which it is difficult to assess if and where the authorities are succeeding and failing in their obligations. Further, the UN's sub-cluster on gender-based violence has not issued standard operating procedures for service providers identifying and treating survivors of sexual violence.

²⁷³ See Request by the International Women's Human Rights Clinic at the City University of New York School of Law, MADRE, Institute of Justice and Democracy in Haiti, Bureau des Avocats Internationaux, Morrison & Foerster LLP, Center for Constitutional Rights, and Women's Link Worldwide for Precautionary Measures under Article 25 of the Commission's Rules of Procedure, October 2010.

²⁷⁴ Human Rights Watch interview with Wannchel, community health worker, camp in Cite Soleil, January 31, 2011.

²⁷⁵ Human Rights Watch interview with Fritznel, male member of women's group in a camp in Port-au-Prince, January 27, 2011.

²⁷⁶ Human Rights Watch interview with Monique, member of women's group in a camp in Martissant, January 29, 2011.

IV. Conclusion

Investing in women is the best investment we can make in any country. And investing in the Haitian women will fuel the long-term economic recovery and progress, not only for them, but for their families.

—Hillary Clinton, Haiti Donor’s conference, UN, New York, March 31, 2010

Many women and girls in Haiti lost husbands or partners, children, and parents in the earthquake. They lost their homes. Those engaged in the informal economy, lost their means to a livelihood. Many can no longer send their children to school, or consistently ensure an adequate supply of food for their families. In some camps, up to a hundred people share a single latrine. Some still share chemical latrines, port-o-potties, installed over 18 months ago. The free provision of water is transitioning to a pay-per-use model. And the threat of cholera still exists. While the number of people living in the displaced settlements has reduced from its peak after the earthquake, women or adolescent girls continue to head the majority of households in the camps.

A year-and-a-half after the quake, people continue to live in wind-shredded tents that offer little protection to the women and girls who spend restless nights inside them. Worse still, many face eviction: the International Organization for Migration (IOM) estimates 25 percent of households in the camps are threatened with eviction.²⁷⁷ In late May 2011, the mayor of Delmas began forcibly evicting families from public spaces.²⁷⁸

Children in the camps are sick from the heat of the tents and the lack of nutritious food. Some women and girls cannot even realize the basic right to choose when to have children. They cannot be sure they will give birth in a safe facility, attended by someone trained in obstetric health.

Haitian women and girls are not just victims of violence, discrimination, or circumstance. They are an integral part of the Haitian economy and society. Yet many women and girls interviewed by Human Rights Watch felt that their concerns have been excluded from Haiti’s rebuilding process. Investing in the women and girls of Haiti requires more than words or vast donor pledges: it requires a fundamental shift in how the state and

²⁷⁷ International Organization for Migration (IOM), Haiti’s camp population still falling, but great challenges remain, April 2011.

²⁷⁸ Valéry Daudier, Le maire Jeudi récupère de force les places publiques de Delmas, *Le Nouvelliste*, May 24, 2011, <http://www.lenouvelliste.com/article.php?PubID=1&ArticleID=92828&PubDate=2011-05-23> (accessed May 30, 2011).

international community approach women and girls, especially those displaced by the earthquake.

The UN independent expert on human rights in Haiti suggests that a rights-based approach be extended to the reconstruction process, as overseen by the interim Haiti Recovery Commission. Such an approach, he argues, would allow for:

a greater focus on the most vulnerable groups, such as women, children and persons with disabilities; the systematic involvement of civil society organizations, in particular those representing women, peasants and vulnerable groups, in the reconstruction effort; the inclusion of gender-specific analyses of and concrete gender-equality targets in reconstruction plans and budgets; and the introduction of measures to ensure that labour-intensive reconstruction programmes are not concentrated solely in the economic sectors traditionally occupied by men.²⁷⁹

Such a fundamental shift would allow for reconstruction aimed at realizing human rights denied to most of Haiti's women and girls long before the earthquake hit.

Reproductive and maternal health is not ancillary to the larger reconstruction process. For all woman and girls in Haiti, fulfillment of their rights to reproductive and maternal health and to live free of violence is fundamental to any effort to rebuild their lives after the devastation and disruption caused by the earthquake. As Haiti slowly struggles to move forward with reconstruction and to relocate those displaced by the earthquake in safe housing, the Haitian government and its partners must ensure that women's and girls' economic and health vulnerabilities are not exacerbated by lack of access to reproductive and maternal care or sexual violence. As Yvonne, who lives in a camp in Croix-des-Bouquets, said, "[We] don't want any more babies right now. Life is too hard in the camps."²⁸⁰

²⁷⁹ United Nations Human Rights Council, Report of the Independent Expert on the situation of human rights in Haiti, Michel Forst, A/HRC/17/42, April 4, 2011, paras. 14-15.

²⁸⁰ Human Rights Watch interview with Yvonne, camp in Croix-des-Bouquets, January 22, 2011.

V. Recommendations

To the President of Haiti

- Develop and communicate a gender policy consistent across all ministries and government policies. The policy should require:
 - A focus on the rights of women and girls, including their rights to reproductive and maternal health;
 - That all data be disaggregated by gender;
 - The inclusion of gender-specific analysis in program and policy design, implementation, and monitoring;
 - Establishment of concrete gender-specific benchmarks and indicators;
 - Clear avenues for women's and girls' participation.
- Design programs to increase women's and girls' access to information on maternal and reproductive care, availability of post-rape care, availability of medical services, and general information about the reconstruction effort.
- Identify and implement measures that can be put in place to ensure adequate oversight, monitoring, and reporting of programs to allow accountability between rights-holders and the state, as well as between the state and donors. This is essential to assess whether responses on the ground are effectively meeting human rights obligations and if not, what remedial action should be taken to fulfill those obligations.
- Create opportunities for political participation of women and girls, particularly those from vulnerable groups, including those living in camps and women with disabilities.
- Strengthen and support the Ministry of Women to fulfill its mandate to eliminate all forms of violence against women and to make the constitutional and legislative reforms to ensure the equality of men and women before the law.

To the Haitian Parliament

- Sign and Ratify the International Covenant on Economic, Social and Cultural Rights, and the Additional Protocol of the American Declaration on the Rights and Duties of Man on Economic, Social and Cultural Rights (Protocol of San Salvador), which further protect women's and girls' right to health.
- Introduce necessary legislative measures that will lead to greater gender equality, particularly those proposed by the Concertation Nationale, including a Family Code for Haiti, a specific law on prevention of domestic violence and intimate partner rape, and assigning legal rights to certain forms of informal unions between men and women, and those currently under review by the Women's Ministry and its partners.

To the Ministry of Health (MSPP)

- Implement a gender policy consistent with the recommendation above.
- Establish a clear bill of rights for reproductive and maternal health patients to be posted in every health facility and orally communicated to every female patient participating in the Free Obstetric Care project (SOG). The bill of rights should include:
 - A description of all services covered under the program;
 - An explanation of how reimbursements of the costs of transportation or traditional birth attendants are made;
 - The right of the patient to continue to receive care under the SOG program, even if she is unable to pay for ancillary services not covered by the program, such as a sonogram or blood test.
- Provide guidelines for medical professionals to explain to patients why these ancillary care services are not covered by the SOG program and why such tests and medicine are nonetheless medically recommended, and to explain that patients may continue to attend prenatal checkups, even if they are unable to pay for the ancillary care.
- Develop procedures and checklists for medical professionals in both public and private facilities to discuss birthing plans with women and girls. The procedures should include discussing: how to recognize signs of early labor, and when to go to the hospital or clinic to give birth; where a women or girl plans to give birth and how she will get there; and how to recognize signs of an obstetric emergency, and where to go in case an emergency arises.
- Train medical professions in state-run and private health facilities on how to recognize signs of gender-based violence in patients, and ensure all staff in such facilities know how to respond to victims of gender-based violence, including which services they should be referred to.
- Design a program for strengthening traditional maternal health expertise that already exists at the camp and community levels and work with NGOs and UN agencies to execute a training program. Include in the training how to recognize signs of gender-based violence, and referral pathways for seeking post-rape care.
- Develop a model for community outreach on family planning, maternal health services and gender-based violence, building on the successful outreach programs implemented in the urban areas to educate the population about cholera prevention.
- Ensure all state-run and private health facilities are stocked with post-rape care kits, including emergency contraceptive and anti-retrovirals.
- Begin developing accountability mechanisms for reporting and investigating maternal deaths in state-run health facilities.

- Raise awareness through information campaigns about the availability of free maternal and reproductive health services in state run health facilities, including emergency contraception.
- Refresh medical professionals on all methods of family planning, including surgical methods.
- Implement a robust medical school curriculum that recognizes women and girls right to health and includes training on all methods of family planning, including training on surgical methods of contraception, on how to communicate effectively with women and girl patients, how to recognize signs of gender-based violence, and referral pathways for victims of gender-based violence.
- Identify and implement measures that can be put in place to ensure adequate oversight, monitoring, and reporting of programs to allow accountability between rights-holders and the state, as well as between the state and donors. This is essential to assess whether responses on the ground are effectively meeting human rights obligations and if not, what remedial action should be taken to fulfill those obligations

To the United Nations Agencies and International NGOs

- Develop and communicate a gender policy consistent across the organization or agency. The policy should require:
 - A focus on the rights of women and girls, including their rights to reproductive and maternal health;
 - All data be disaggregated by gender;
 - Disaggregated data should be shared with relevant actors, including government entities;
 - Inclusion of gender-specific analysis in program and policy design, implementation, and monitoring;
 - Establishment of concrete gender-specific benchmarks and indicators;
 - Clear avenues for women’s and girls’ participation.
- Identify traditional birth attendants, nurse auxiliaries, or others trained in basic first aid living in camps. Provide training to them to increase their capacity and knowledge. Communicate clear referral pathways for obstetric emergencies and ensure they have the means to access these pathways, including by providing cellular phones and emergency telephone numbers. Supply traditional birth attendants with clean birthing kits. Educate traditional birth attendants to contact agencies or NGOs should an infant or maternal mortality occur in the camp.
- Provide timely reporting to the ministry of health on the number of prenatal visits, institutional births, and maternal and infant deaths in NGO-managed facilities.

- Camp managers should provide the ministry of health with timely and accurate reports of maternal and infant deaths in camps.
- Coordinate with the Ministry of Health to prioritize reproductive and maternal health services.
- Work with the Ministry of Health and the Free Obstetric Care project (SOG) to establish Maternal Mortality Surveillance Committees in earthquake-affected areas to connect communities to health institutions, following the successful model of Port-Salut and Aquin but adapted for the urban area of Port-au-Prince.

To the Interim Haiti Recovery Commission

- Develop and communicate a gender policy consistent across the commission and proposing organizations. The policy should require:
 - A focus on the rights of women and girls, including their rights to reproductive and maternal health;
 - All data be disaggregated by gender;
 - Disaggregated data should be shared with relevant actors, including government entities;
 - Inclusion of gender-specific analysis in program and policy design, implementation, and monitoring;
 - Establishment of concrete gender-specific benchmarks and indicators;
 - Clear avenues for women’s and girls’ participation.
- Encourage proposals that invest in women’s and girls’ health and security.
- Require that all proposals to the commission include gender-specific analysis in program and policy design, implementation, and monitoring, and have concrete gender-specific benchmarks and indicators. Data provided to the commission should be disaggregated by gender.
- Require that projects that the commission approves follow rights-based principles, including the indivisibility and interdependence of all human rights, non-discrimination and attention to vulnerable groups, accountability, and participation.
- Increase women’s participation on the commission, including by increasing the number of Haitian women representatives.

To Donors States and Agencies and Multilaterals

- Fund projects in line with the Ministry of Health’s priorities for maternal and reproductive care.
- Develop and communicate a gender policy consistent across the agency. The policy should require:

- A focus on the rights of women and girls, including their rights to reproductive and maternal health;
- All data be disaggregated by gender;
- Disaggregated data should be shared with relevant actors, including government entities;
- Inclusion of gender-specific analysis in program and policy design, implementation, and monitoring;
- Establishment of concrete gender-specific benchmarks and indicators;
- Clear avenues for women’s and girls’ participation.
- Require implementing partners to include gender-specific analysis in bids, program and policy design, implementation, and monitoring and have concrete gender-specific benchmarks and indicators.
- Avoid disruptions in aid money that could cause discontinuity in health care services and have an impact on women’s health.
- Disburse pledged funding.
- Collaborate with the Ministry of Health to develop an electronic mapping of the health sector to identify geographical or other gaps in medical services.
- Ensure adequate oversight, monitoring, and reporting of programs to allow accountability between donors (and implementing NGOs) and the government of Haiti.
- Ensure implementing partners adopt a rights-based approach, including providing opportunities for beneficiaries to participate in project planning or seek redress for violations of their rights.

To the United Nations Stabilization Mission in Haiti (MINUSTAH), UNPOL, and Haitian National Police (HNP)

- Ensure proper follow-up when cases of gender-based violence are identified.
- Ensure victims of gender-based violence understand what medical services are available to them and have access to these services.
- Seek feedback from camp representatives, particularly women and girls, living in patrolled camps on the efficacy of patrols and identify ways to improve security for women and girls in the camps.
- Continue to follow the Department of Peacekeeping Operations Guidelines for Integrating a Gender Perspective into the Work of United Nations Military in Peacekeeping Operations and monitor implementation across all forces in the mission.

To the United Nations Special Procedures of the Human Rights Council

- The special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health should visit Haiti to assess the impact of the earthquake and recovery on the right to health and health-systems.
- The special rapporteur on violence against women, its causes and consequences, should make a follow up to her June 1999 country visit.
- The independent expert on the situation of human rights in Haiti should continue his significant efforts to date to encourage the Interim Haiti Reconstruction Commission and humanitarian actors to adopt a rights-based approach to recovery and reconstruction. He should continue to monitor the adoption of a rights-based approach by these actors.

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“Nobody Remembers Us”

Failure to Protect Women’s and Girls’ Right to Health and Security in Post Earthquake Haiti

Despite an unprecedented influx of financial aid, the state of maternal health in post-earthquake Haiti remains precarious. Prenatal and obstetric care is inadequate. Many women have no access to contraceptives, including emergency contraception after rape, and many of the 300,000 women and girls who still live in displacement camps engage in sex for food or money in order to survive. The crisis is reflected in pregnancy rates in the camps that are three times higher than in urban areas before the earthquake, when rates of maternal mortality already ranked among the world’s worst.

Human Rights Watch interviewed 128 Haitian women and girls living in 15 displacement camps, in order to document these and other barriers to maternal health in post-earthquake Haiti. Access to even the most basic information related to reproductive and maternal health is severely limited. Even the small costs of transportation to and from health facilities or fees for medical prescriptions create serious obstacles for women and girls seeking health services. Women and girls who are consequently unable to access these services face further risks when they give birth in the unhealthy conditions of the displacement camps. This report also describes the impact of rape and survival sex on women’s and girls’ reproductive health, and the limited access to medical services necessary to prevent unwanted pregnancy.

Long before the earthquake the government of Haiti was dependent on international aid to provide health care, and to address the problem of sexual violence. In the post-earthquake context donors should help the Haitian government to set up the oversight and accountability structures necessary to ensure that the rights of women and girls to adequate health care are protected. Without this assistance, women and girls living in the camps may not benefit from those services that are available to them and cannot seek a remedy when problems or abuses occur.

Human Rights Watch calls on all actors in Haiti to prioritize the protection of women and girl’s rights to maternal and reproductive health care in recovery efforts, and to ensure transparency and accountability in the provision of this protection, including by non-governmental actors.

A pregnant woman receives condoms from an NGO medical team conducting mobile clinics in the camps around Port-au-Prince following the earthquake.

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