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Evaluation of Post-Earthquake Physical Rehabilitation Response in Haiti, 2010 – a systems analysis

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Foreword

The earthquake that hit Haiti in January 2010 was of unprecedented scale. Poverty – manifested by malnutrition, poor health and education services – were already widespread. The earthquake exacerbated the situation, destroying infrastructure and lives. Where the general population lacks access to basic services and people live in poor conditions, a disaster, like the Haitian earthquake, particularly impacts people with disabilities.

The Haitian Government estimates that the number of persons with disabilities in Haiti following the disaster is 1.1 million (1 in 7 of the population). They need access to health, education and rehabilitation services.

As part of its humanitarian work in Haiti, CBM supported an evaluation of the post-emergency rehabilitation response in order to assess what had been achieved, learn from good and not-so-good practice, and promote the development of an effective rehabilitation sector in the future.

This evaluation provides evidence, to inform CBM and other humanitarian organisations, about what must be done in a post-disaster situation so that people with disabilities have access to relief and protection on an equal basis with others, and what is required in the long-term to develop a good rehabilitation service.

CBM wishes to thank the research team at the International Centre for Evidence in Disability at LSHTM, for carrying out the study and providing the report and recommendations. We also thank the CBM team in Haiti for making the study possible and to all the participants who shared their knowledge and experience.

Prof. Allen Foster OBE, President, CBM

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Preface

This summary report describes the findings of a nine-month study conducted in Haiti by Karl Blanchet, Lecturer, and Myroslava Tataryn, Research Assistant, at the International Centre for Evidence on Disability, London School of Hygiene and Tropical Medicine. Full responsibility for the text of this report rests with the authors. The views contained in this report do not necessarily represent those of CBM or of the people consulted. The authors sincerely thank CBM for their financial support received and the CBM team in Haiti for their help in facilitating the work of the researchers.

Karl Blanchet and Myroslava Tataryn,
International Centre for Evidence on Disability,
LSHTM, London, UK. March 2012

Acronym key

ALNAP	Active Learning Network for Accountability and Performance (in Humanitarian Action)
CBM	Formerly known as Christian Blind Mission
CEO	Chief Executive Officer
CONARHAN	*Le Conseil national de réhabilitation des handicaps* (National council on rehabilitation of the disabled)
CRPD	Convention on the Rights of Persons with Disabilities
DPO	Disabled People's Organisation
DVFP	Disability and Vulnerability Focal Points
GDP	Gross Domestic Product
HCRI	Humanitarian and Conflict Response Institute
HI	Handicap International
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
I/NGO	("Hybrid") International Non-Governmental Organisation
INGO	International Non-Governmental Organisation
IRD	Injury, Rehabilitation, and Disability
IRDW	Injury, Rehabilitation, and Disability Working Group
LSHTM	London School of Hygiene and Tropical Medicine
M&E	Monitoring and Evaluation
MAST	*Ministère des Affaires Sociales et du Travail* (Ministry of Labour and Social Affairs)
MDG	Millennium Development Goal
MINUSTAH	United Nations Stabilization Mission in Haiti
MSF	*Médecins Sans Frontières* (Doctors Without Borders)
MSPP	*Ministère de Santé Publique et de la Population* (Ministry of Population and Public Health)
NGO	Non-Governmental Organisation
OCHA	Office for the Coordination of Humanitarian Affairs
OT	Occupational Therapy
P&O	Prosthetics and Orthotics
PT	Physiotherapy
SCI	Spinal Cord Injury
SEIPH	*Secrétaire d'État à l'Intégration des Personnes Handicapées* (Secretary of State for the Integration of Persons with Disabilities)
US	United States (of America)
UN	United Nations
UNDP	United Nations Development Program
UK	United Kingdom
USAID	United States Agency for International Development
WHO	World Health Organization

1 Executive summary

Study objective

The objective of this study, carried out by the London School of Hygiene & Tropical Medicine and funded by CBM, is to assess the impact of the emergency response on the rehabilitation sector in Haiti, following the 2010 earthquake.

Main findings

- The rehabilitation sector in Haiti after the earthquake was composed of a variety of actors with sometimes conflicting approaches;
- The coordination mechanism focused on day-to-day activities, neglecting the building of a common vision for the future;
- The range of services offered to people with disabilities in Haiti was greater after the emergency response thanks to the introduction of new services.

Several aspects were considered, under the following headings:

Coordination

- The creation of the Injury, Rehabilitation and Disability Group within the Health Cluster had a positive impact on emergency response coordination
- Compared to the health sector in general, the rehabilitation sector was quick to bring Haitian actors on board and give the lead to national actors

Relationships with national authorities

- Co-chairs of the cluster, CBM and HI invested efforts to make Haitian authorities central to the sector (e.g. shared responsibilities for services)
- Full participation of national authorities was challenged by personnel turnover, political instability and unclear division of responsibilities

Social network of the rehabilitation sector

- The rehabilitation sector was composed of over 125 actors of various natures, sizes and roles, which hampered creation of coherence between them
- The two international NGOs CBM and HI generated most of the ties between rehabilitation actors

From emergency to development

- Four months post-disaster, more than half the people receiving rehabilitation services were not earthquake victims, revealing the high needs not covered by services prior to the earthquake
- The emergency phase attracted professionals into Haiti both to respond to the needs of the disaster victims and to help build for future needs
- Local populations perceived the high turnover of international staff in the emergency period as a major obstacle to building local capacities

Service delivery

- The short-term contracts among international teams and a lack of systematic record-keeping compromised the ability to pass on useable information to Haitian health care services
- Instability discouraged Haitian practitioners, encouraging out-migration and jeopardising the quality of ongoing care for people with disabilities
- Some smaller organisations lacked experience in humanitarian settings and familiarity with international guidelines

Key recommendations

- Meetings should focus more on the future and what every actor should do to build the rehabilitation sector
- Meetings should be held in an accessible location, in the country's official language/s (and/or with translators)
- NGOs, INGOs, and I/NGOs should ensure that their staff are aware of international standards concerning rehabilitation response
- Rehabilitation professionals should be trained in emergency response (or have experience in the affected country) before intervening post-disaster
- To ensure the necessary follow up and continuity of care, rehabilitation actors must start building towards the future of the sector from the early stages of the emergency phase
- Seize opportunities to increase the positive profile of people with disabilities and strengthen disability rights in the country through holistic rehabilitation services
- Governmental and civil society stakeholders should be involved and – as duty bearers – take over responsibilities as early as possible in the development of rehabilitation services, not merely informed of them.
- INGOs and I/NGOs must budget for the extra time that may be necessary to involve local authorities. International organisations must be prepared to work more slowly than they may wish, if they seek to develop sustainable programmes.

2 Background

History

Haiti was the first country in the world to have a successful slave rebellion, leading to independence in 1804. As a condition of recognising the new republic's independence, however, France demanded payment of 150million gold Francs.

The debt was reduced to 90million in 1838, but Haiti was essentially ransomed for the next 150 years. Even after repaying this debt in the middle of the 20th century[1], Haiti continued to suffer severe economic difficulties, while chronic political instability further impaired economic and social development[2].

Existing rehabilitation services and disability movement

Prior to the earthquake, data regarding the scale of rehabilitation needs in Haiti were unavailable. The importance of rehabilitation services was unrecognised by the government, service providers thus received little support[3], and services were financed and administered almost exclusively by external organisations.

Physiotherapy and orthopaedic services were scarce, and outside Port-au-Prince services were "virtually non-existent"[7]. Prosthetic and orthotic services (P&O) were very weak with only 3 workshops in the country, in-patient rehabilitation services were rare, and no treatment for Spinal Cord Injured patients existed in Haiti before 2010[4-5].

Training of rehabilitation practitioners was, and is limited, so that most trainees must travel to Dominican Republic or further afield, while the low demand in Haiti before 2010 discouraged foreign-trained professionals from returning to Haiti to practice.

The disability movement has lobbied for decades in Haiti[10,a] for social inclusion of people with disabilities and the provision of disability-related services including rehabilitation. The *Bureau du Secrétaire d'Etat à l'Intégration des Personnes Handicapées* (Office of the Secretary of State for the Integration of Persons with Disabilities – known as SEIPH) was established in 2007, to promote disability rights within Haitian government structures. The *Conseil national de réhabilitation des handicaps* (National Council on Rehabilitation of the Disabled or CONARHAN) was formed in 2008 in order to provide expertise to SEIPH and the *Ministère de la Santé Publique et de la Population* (Ministry of Health or MSPP).

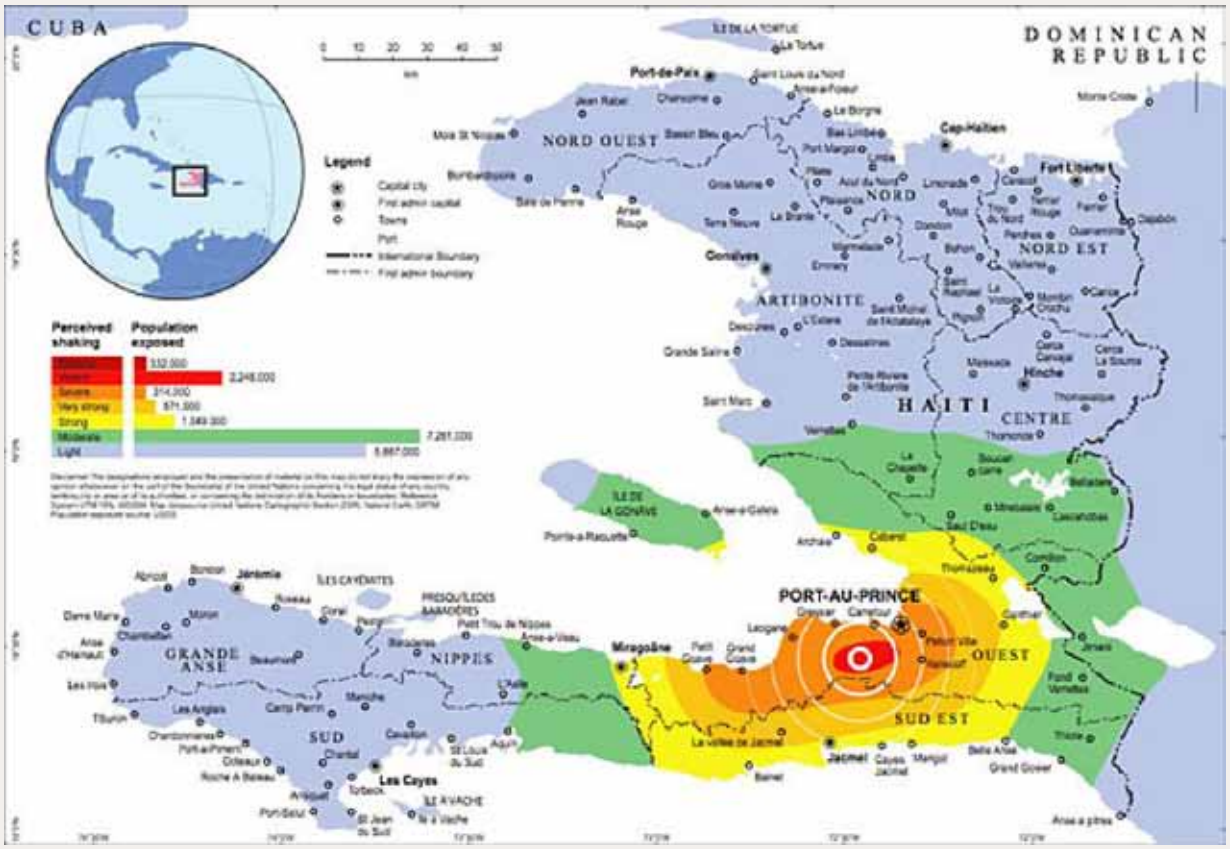
The Haitian disability movement (including government, charitable disability service organisations and disabled people's organisations) was successful in its advocacy for ratification of the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD). Haiti signed and ratified the Convention in July, 2009[6].

The earthquake, the impact and the response

The earthquake on 12 January 2010 measured 7.0 on the Richter Scale, killing 222,570, injuring 300,572 and displacing 2.3 million people throughout the country[7]. Between 2,000 and 4,000 amputations resulted from earthquake-related injuries[8].

a From an unrecorded conversation during a meeting with OAS staff members in Port-au-Prince on 13 June 2011.

Figure 1: OCHA map of Haiti with the epicentre of the earthquake marked in red



Map sourced from: reliefweb.int/node/15299 (Accessed: 31 October 2011)

The Haitian health system including the rehabilitation sector, small as it was, suffered immense damage[7-8]. Total damage and loss to the country was estimated at US $7.8billion – more than Haiti's GDP in 2009[7]. Damage to human life and infrastructure at governmental and other top-levels weakened the Haitian response and coordination mechanisms, impairing their ability to act quickly.

The rapid, multi-sectoral international response brought together UN agencies, international military forces, government and non-governmental actors, using existing NGO and UN networks in-country to respond swiftly[7, 9-10]. Haitian civil society provided immediate assistance to the affected and displaced population[7], while local people were in the vanguard, pulling victims from rubble and blocking off streets to improve security minutes after the earthquake struck[7, 10].

Thousands of international organisations intervened[2, 7]. The multitude and diversity of participants generated many evaluations and assessments[11], including the 30 evaluative reports which were analysed for this study, along with seven articles in peer-reviewed journals.

Focal issues in these reports included: coordination, participation by Haitian actors, sustainability, and relationships between humanitarian actors, military forces and vulnerable populations. The authors of this study took particular note of publications specifically concerned with disability and rehabilitation.

The most prevalent criticism of the response was poor coordination, particularly in terms of poor communication between service providers, weak adherence to national and/or international standards and noticeably competition between providers in certain geographic areas while others remained underserved[2, 7, 11-12]. The 'cluster' coordination model was criticised in Haiti for its top-down implementation, which showed little recognition of or respect for existing national structures[23].

National authorities and civil society felt excluded from coordination meetings, which were held in an inaccessible location – the MINUSTAH logistics-coordinating base ('logbase') – and in English rather than in the local languages of French or Haitian Creole[7, 13-14].

3 Methodology

Timeline

The project began in January 2011 with London-based preparatory work. Fieldwork in Haiti was conducted through the course of 3 visits: a first, preliminary, exploratory visit in March 2011; a second visit in May – June during which the majority of data were collected; and A third visit in October 2011 when we shared preliminary results and clarified outstanding questions before final revisions of the report in November.

Participant selection

Prior to the first field-visit, actors in the rehabilitation sector were contacted from a list in the *Haitian Rehabilitation Sector Update: January 2011* compiled by USAID. We followed up with respondents to our initial email during the field visit in March. Additional contacts made through CBM staff, and other contacts, on the first trip were interviewed on the second visit in May–June.

Data collection

Data were collected using a variety of qualitative methods: in-depth interviews; observation of rehabilitation sites in Haiti; review of organisational documents and statistics; and social network analysis. Qualitative methodology aims to elicit in-depth data from a relatively small number of participants representing a broad range of experiences and perspectives.

Face-to-face interviews

Sixty-one in-depth, guided interviews and two focus group discussions were conducted in French or English. Interview guidelines were developed separately for each stakeholder group: (i) CBM staff; (ii) actors operating at a national level; (iii) actors operating internationally.

Questions were designed to elicit information about the dynamics of the rehabilitation response in 2010, coordination between actors and its influence on disability mainstreaming in broader humanitarian efforts.

Observations and informal discussions

Observations and informal discussions with clinicians and project staff were conducted in eight rehabilitation centres in Port-au-Prince and surrounding communes. These observations were usually conducted as part of a tour offered by the centre director or manager. Introductions to clinical staff were made during these tours and resulted in informal discussions about staff experiences post-earthquake, ongoing centre development, and shifting demographics of patients in 2010 and early 2011.

Review of organisational documents and statistics

Each rehabilitation provider contacted was asked to complete a questionnaire. Questions included the number of users accessing services in 2010 and demographics of these users, sources of funding and country of origin of these funds, number and expertise of staff employed. The goal was to obtain these data in order to assess shifts in services over the year, although in the majority of cases this level of specificity was unavailable. In cases where existing records were made available to researchers the provider's activity reports were reviewed as additional sources of data regarding the centres' activities.

Social network analysis

The social network analysis adapted to the study of rehabilitation systems consists of three main stages: (i) describing the set of actors and members of the network; (ii) characterising relationships between actors; and (iii) analysing the structure of the systems. Evidence generated through social network analysis assists with the understanding of how systems (such as the rehabilitation sector in Haiti) react over time, how ties between actors can influence systemic behaviour and changes within that system.

Each of the organisations contacted was provided with a list of actors in the rehabilitation sector in Haiti and asked to indicate (a) to whom they provide financial or technical support and (b) from whom they receive financial or technical support. If they have such a relationship with another organisation they were asked to indicate the missing organisation/s on their form so that these could be added to the list. Data were fed into the visual representation of the social network of the Haitian rehabilitation sector (Figure 2).

Ethics

Before recording interviews or focus-group discussions, participants provided written consent in accordance with LSHTM ethics procedures. This study obtained official ethics approval from the LSHTM Ethics Committee as well as the Ethics Committee of the Haitian Ministry of Health.

Analysis

Data were analysed by identifying recurrent themes arising during interviews, focus group discussions, and informal conversations. Particular attention was given to the presence or absence of references to themes identified in evaluations from other sectors of humanitarian response, during the literature review conducted prior to field visits.

After data were analysed thematically, a comparative analysis was conducted between themes arising from data in the rehabilitation sector and themes documented in broader humanitarian evaluations.

4 Results

The rehabilitation sector

Physical rehabilitation is a large domain including treatment for new injuries, reducing or lessening permanent disability as a result of injury, supporting persons adapting to newly acquired disabilities with physical and occupational therapy, physical and occupational therapy, providing prosthetics and orthotics and other mobility aids, and the range of medical and lifestyle adjustments necessary after spinal cord injuries in order "to achieve and maintain optimal functioning in interaction with their environments"[15].

Rehabilitation is slowly gaining recognition as an important component of humanitarian response. This is recognised by the 2010 edition of the SPHERE Guidelines which also point out that, "early rehabilitation can greatly increase survival and enhance the quality of life for injured survivors" and that, "where available, partnership with community-based rehabilitation programmes can optimise the post-operative care and rehabilitation for injured survivors[16]".

In addition to the services offered to people injured in the earthquake, this study also considered accessibility of rehabilitation services to a wider population including people with physical impairments acquired due to causes unrelated to the earthquake. There is a need for emergency services to transfer into development projects in contexts such as Haiti.

Cluster model and coordination

The cluster coordination model for disaster response was re-activated in Haiti to coordinate post-earthquake humanitarian responses. The model is intrinsic to large disaster responses, especially in contexts where structures are weak in the first place[17]. Although the approach is seen to improve coordination, it was criticised in Haiti for being implemented in a top-down fashion with little respect for existing national structures[14]. Concerns were also expressed that clusters created silos of aid rather than allowing collaboration to tackle 'cross-cutting' issues [12]. Therefore, ensuring the adoption of standards or benchmarks for issues such as gender or disability mainstreaming can be difficult to implement.

Relationship with Haitian government

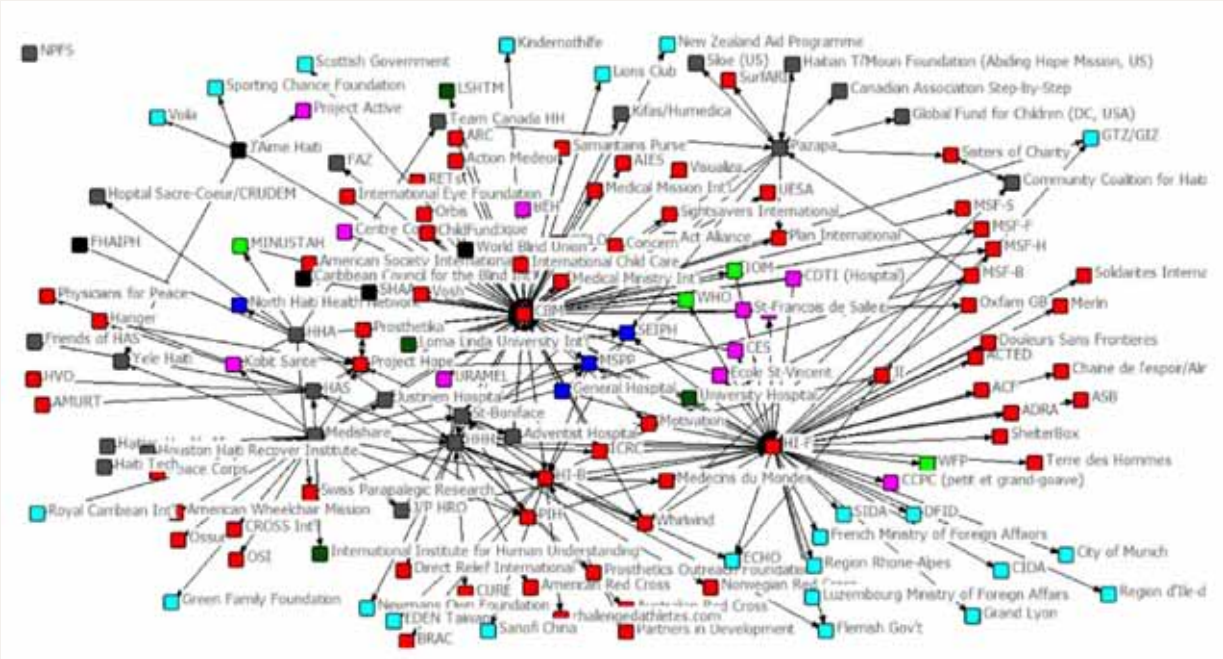
Each of the 30 reports reviewed mentioned lack of participation by the Haitian government and civil society in the humanitarian response[7, 11]. Interviewees referred to challenges involved in working with Haitian government ministries, offices or agencies. Nevertheless respondents agreed that the involvement of the Haitian state and increased ownership of the rehabilitation sector is crucial for the evolution of the sector. There is consensus in evaluations that the majority of international actors lacked connection to the Haitian context[13].

Haitian actors felt excluded from coordination meetings for two main reasons:

1. Coordination meetings were held in the MINUSTAH[b] logistics-coordinating base[c], which was not easily accessible for local actors
2. Most meetings in the first 2-6 months were held in English[d], discouraging Haitian official and civil society participation[7, 13-14]

b UN Stabilization Mission in Haiti (MINUSTAH) has had a presence in the country since 1 June 2004 (see: http://www.un.org/en/peacekeeping/missions/minustah/; Accessed 22 Sept 2011).
c Referred to as 'logbase'.
d French and Haitian Creole are the two official languages in Haiti.

Figure 2: The social network of the rehabilitation sector in Haiti in late 2010



Key: ■ DPO; ■ Donor; ■ Government body (Haitian); ■ INGO; ■ Haitian NGO; ■ Hybrid I/NGO; ■ UN; and ■ Universities.

It is important not to conflate the involvement of government with that of civil society in a context where trust in government is often lacking[2], and where national government involvement does not necessarily translate into endorsement on the part of the general population. Emphasis must be placed, however, on strengthening government systems. A large, poorly coordinated humanitarian response may further weaken the state as the public looks to NGOs to fulfil state responsibilities[16].

Clinical record-keeping and data collection

CBM, HI, and SEIPH shared a database of clinical records from the DVFP sites (January – December 2010), which became the most viable source of data on injuries and rehabilitative care available in Haiti at the time[e]. The success of the shared resource demonstrates that standardisation of data collection is possible across organisations, albeit requiring a considerable amount of inter-organisational communication and collaboration, and well-trained staff. The collaboration on the database project was sadly not extended past 2010. Records are once again restricted to specific organisations, making comparison between projects, centres and organisations difficult, as each adopts its own data collection system. This will also make the possible future task of creating a national database more challenging. Similarly, Haiti Hospital Appeal established an SCI patient database in March 2010, collated from several members of the Haiti SCI Working Group including Healing Hands for Haiti[f]. The goal was centralising information on SCI patients to improve the quality and continuity of care they receive over time from different clinicians and service providers. This initiative was extended beyond 2010, but the database is currently managed solely by one individual and there are fears about its sustainability. Nor has it yet been integrated into national health information systems by the MSPP.

Social network analysis

The image above (**Figure 2**) is a visual representation of the rehabilitation sector in Haiti in May 2011. This description of organisational relationships was compiled based on descriptions given in meetings and interviews

e This assertion is being made by a HI/HCRI study that is due to be published in Dec. 2011, but preliminary results have been shared with M. Tataryn.

f Information on SCI database obtained from ongoing email communication with ID1 between March – Nov 2011.

with project coordinators at 24 rehabilitation and/or disability-focused organisations. The network is characterised by many diverse actors oriented around two nodes: the co-chairs of the IRD Working Group of the Health Cluster CBM and HI.

Haitian government ministries and agencies were connected to the centre of the network, but did not have many connections of their own with rehabilitation actors. As co-chairs of the IRD Working Group until the end of December 2010, HI and CBM played the role of social brokers by creating bridges between actors from different groups.

Emergency or development needs?

Haiti is in regular need of both humanitarian responses to disasters, and of development-oriented interventions to strengthen governance, education, health, and other social systems[18]. The UN's peacekeeping force MINUSTAH has been in Haiti since 1994[19], adding further layers of complexity to humanitarian efforts. SPHERE Guidelines state that, "the way health interventions are planned, organised and delivered in response to a disaster can either enhance or undermine the existing health systems and their future recovery and development"[16]. It is difficult for humanitarian organisations to withdraw, where there are no suitable national structures to which responsibilities can be passed.

There was much discussion as to whether one year after the earthquake Haiti was in an 'emergency' or 'development phase'. Yet, 'Disability and Vulnerability Focal Points' and clinics reported a drop in numbers of earthquake-injured patients as early as May 2010, and a steady rise in people presenting with new or previously untreated injuries and other pathologies and congenital physical impairments[g]. This was a signal for many INGOs to consider a shift from 'emergency' to 'development' programmes.

Many respondents mentioned that 'emergency' funds provided an opportunity to respond to the long term needs of the population and build a rehabilitation sector in Haiti for the first time, including physiotherapy for new amputees and a range of nursing, physical therapy and occupational therapy services for people with spinal cord injuries, none of which had existed in Haiti before 2010.

Funding

The Haitian earthquake received widespread media coverage and financial support from private, charitable, bi-lateral and state sources. Respondents expressed concern about the various funding priorities and additional human resources needed to satisfy donors' requirements, which diverted attention from delivery of programmes. Media reports fuelled funding and were perceived to direct funding priorities[20].

Fundraising offices that do not usually participate in programme activities sent staff to Haiti to make decisions about how and where funds should be spent, complicating lines of communication for field staff and creating an increased burden of reporting to satisfy donors and headquarters. In the months following the earthquake, accommodation and transportation was difficult to find and the extra visitors increased demands on logistical staff and coordinators.

Just one year after the earthquake, project coordinators were worried about project sustainability and continuity of funds. Respondents reported widespread donor fatigue and disillusionment with Haiti, but because of current and historical environmental and political situations it is unrealistic to expect rapid change. Field personnel, however, are naturally more cognisant of this fact than international donors and media.

g This was discussed at length on 17 March with ID1 during the visit of a clinic run by an I/NGO in Port-au-Prince. Because the discussion took place during a tour, it was not audio-recorded.

Haitian opinions of the response

Media reports in 2011 suggested that a great deal of money was spent in Haiti with little evidence of change. As well as contributing to donor fatigue this also increased frustration among Haitians. Widespread disgruntlement was reported with the lack of results from international interventions, and there was a sense that had the money been given directly to Haitian organisations it would have gone much further in terms of improving the country.

In early 2011, MINUSTAH security updates included warnings of physical violence and damage to INGO property, attributed to frustration with the perceived ineffectiveness of foreign interventions. An INGO's property was damaged after rumours spread that INGOs were wrapping-up projects and leaving the country; local people had perceived this as abandonment and expressed frustration[h].

Local staff

Largely attributed to the influx of well-intentioned but inexperienced volunteers, our interviews included several accounts of displacement of local staff by foreign personnel: "The international volunteers would come and they wouldn't necessarily appreciate that these guys are the professionals and that they're the ones in control" [20].

The influx of voluntary labour had larger, unintended consequences, as the government ruled that for the first 6–10 months post-earthquake all medical services in the country would be provided free of charge. Although well-meant, the result was that Haitian medical professionals were expected to work on a voluntary basis. Respondents reported that wages were not paid for months, prompting an even greater brain drain that is normal in Haiti, as trained professionals left to work abroad.

Where expatriate staff worked alongside local personnel, it was reported that short-term volunteers did not help improve the training, knowledge or clinical practice of local staff. Due to the high turnover rate of volunteers and lack of continuity of practices between the different organisations, there was little uptake of new skills or techniques. Consequently, local staff resorted to what they already knew to avoid confusion between the disparate approaches of transient volunteer teams: "The Haitian staff just switch off because they know that the team are going to be there for 5, 6, days and then... the next team's going to come with a whole different way of doing things... It's disastrous"[21].

There are positive accounts of hiring and building the capacity of local staff, such as with Healing Hands for Haiti: though its country director and two other staff members are expatriate, all three are in the country for the longer term, and the Medical Director and senior clinical personnel are Haitian[i].

An emerging concern in 2011 was the discrepancy between what local and some I/NGOs are paying their staff versus salaries offered by INGOs. Some organisations felt they could only afford to provide quality rehabilitation services by using visiting volunteers. They could not afford to pay local staff. This dilemma raised important questions about organisational priorities and service provision versus the building of sustainable systems. This echoes the distinction between emergency and development phases, suggesting that organisations in Haiti may not be moving quickly enough from an emergency-oriented, service-delivery mind set to a longer-term development-oriented perspective.

h Based on personal observation in March, May and June 2011.

i Study researchers met and interacted with these staff members in March, May, June and October 2011.

The rehabilitation response

Table 1: Types of services delivered, in 2010, by rehabilitation service organisations in Haiti

			Rehabilitation Services[j]				Others[k]	
Organisation[l]	Country of Origin	Base in Haiti	P&O	PT/OT	SCI	Wheel-chairs[m]	Medical[n]	Non-Medical[o]
Adventist Hospital	USA	Port-au-Prince		x			x	
CBM	Germany	Port-au-Prince		x	x			x
Ecole St Vincent[p]	Haiti	Port-au-Prince		x				x
Haiti Hospital Appeal	UK	Cap-Haitian			x			x
Memphis Medical Missions in Haiti	USA	Port-au-Prince	x (c/o another FBO[q])	x			x	
Handicap International Be	Belgium	Port-au-Prince	X		x		x	
Handicap Int'l Federation	France	Port-au-Prince	X	x	x	x		X
Healing Hands for Haiti	USA	Port-au-Prince	X	x	x	x		
Hopital Albert Schweitzer	USA	Des Chapelles	x (c/o Hanger)	x			x	
Johanniter International	Germany	Leogane	X	x		x	x	
Mission of Hope	USA	Not available	X	x				
Nos Petits Freres et sœurs	Mexico	Port-au-Prince	x	x			x	X
Pazapa	Haiti/ Canada	Jacmel		x				X
Project Hope	USA	Port-au-Prince	x	x			x	
ProsthetiKa	USA	Port-au-Prince	x	x				
St. Boniface Haiti Foundation	USA	Fond-des-Blancs		x	x	x	x	x
Total			**9**	**15**	**5**	**6**	**7**	**9**

j Although respondents were asked about CBR services, the majority of CBR initiatives were started in 2011 and therefore were not included in this table.
k Other services indicated simply to give an idea of scope of the organisation.
l This is not an exhaustive list of rehabilitation service providers in Haiti, merely those who completed our questionnaire.
m Wheelchairs separated because of specific advocacy issues concerning their distribution. Provision of other mobility devices is encompassed within PT/OT.
n May include psycho-social/mental health interventions, surgical services, primary health care, dental clinics, and/or nutrition clinics.
o May include microfinance, shelter/housing, accessibility, disability-rights advocacy, education, distribution of non-food items and/or protection activities.
p St-Vincent's facilities were severely damaged in the earthquake, and it is not clear how their services were rolled out in 2010. Their emphasis was on education (ie. Other: non-medical).
q FBO: Faith-Based Organisation.

The rehabilitation response *continued...*

The rehabilitation response in Haiti post-earthquake was immense compared to other disasters, such as the 2004 Indian Ocean Tsunami. There was a great need for rehabilitation interventions due to the number of injuries sustained[4, 7]. In addition to greater need, the size of the response may also be attributed to Haiti's proximity to the USA, which expedited the arrival of equipment, personnel and also media teams. During interviews for this study, fears were expressed that in some cases the rehabilitation response was driven by media rather than motivated by real needs.

Despite differences, there were also common challenges – particularly with record keeping and clinical data collection. Interviews prompted many discussions about the future of rehabilitation services in Haiti, with a major focus on the development of training programs.

Prosthetics and orthotics (P&O)

The P&O sub-sector of rehabilitation services saw tremendous growth in the provision of services after the earthquake. According to respondents, distribution of resources within the disability sector is uneven and favours physical rehabilitation vis-à-vis other sub-sectors.

Physiotherapy and occupational therapy (PT/OT)

According to the USAID survey[22], 18 of the 33 (55%) organisations reported providing physiotherapy services in 2010, while 15 of the 17 (88%) organisations responding to this study reported providing physiotherapy and other general medical rehabilitation services. The largest providers in PT/OT and other general rehabilitation services were CBM and HI.

From 17 January until July 2010, CBM and HI worked together to provide direct assistance to hospitals, as well as setting up a total of 9 Disability and Vulnerability Points (DVFPs) providing site-based rehabilitation services as well as serving as bases for mobile teams [23]. It was also CBM and HI, together with the Secretary of State for the Inclusion of People with Disabilities (*Secrétaire d'Etat à l'Intégration des Personnes Handicapées* or SEIPH), who were responsible for chairing the IRD Working Group within the Health Cluster.

Spinal Cord Injury (SCI) care

Before the earthquake, people with spinal cord injury in Haiti were not expected to survive for more than a year or two after their injury[4]. Thanks to the rapid and low-cost interventions provided post-disaster and improved staff training, SCI patients now survive longer than was previously thought possible[24].

This study found five actors of the 17 reporting activities in the SCI sub-sector, compared to 15 in PT/OT and nine in P&O. The small number of participants may explain why the SCI sub-sector seemed better coordinated and more cohesive. Two of the three providers of long-term inpatient SCI care in Haiti had no previous history providing SCI services, although both had been delivering medical services in Haiti for several years prior to the earthquake, as described by the manager of an SCI service provider.

5 Discussion

The following discussion highlights similarities and differences between the overall humanitarian response in Haiti and what was observed in the rehabilitation sector. It leads to the recommendations in the final chapter, aimed at improving rehabilitation services delivered in future post-disaster humanitarian responses.

Similarities with general international humanitarian response

Coordination

One of the particular features of the general humanitarian response to the 2010 earthquake was the many international actors with little or no experience in humanitarian operations[7, 12-13, 25], and this was also apparent in the rehabilitation sector.

The devastation faced by Haitian government, UN and NGO structures, and the consequent difficulty in coordinating the international humanitarian response with government and civil society was mentioned in each of the evaluations reviewed. Some stated emphatically that international agencies should be held accountable for the lack of local involvement[11], while others attributed the disjuncture to damage wreaked by the earthquake itself[13]. The opinions of this study's respondents from the rehabilitation sector reflected such variation.

Need for international standards and regulation

The need for stronger international standards for humanitarian agencies acting post-disaster was highlighted in the general humanitarian response, as well as within the rehabilitation sector. The lack of regulation of actors can be partly attributed to the fact that soon after the earthquake, Haiti found itself in what became a very protracted election process: the government of President René Préval did not show a strong presence during its last term in office.

Informal conversations with UN and government officials revealed that Haitian civil servants were frustrated by the many small humanitarian agencies operating without informing the government. These actors considered themselves accountable to their donors (eg. church or charity group) and not to local authorities. Our conversations suggested that larger INGOs (such as MSF, ICRC, etc.) demonstrated more accountability to local authorities, compared to smaller INGOs.

Despite the perceived need, however, such standards (eg. SPHERE Guidelines) will always remain voluntary at an international level – only at national level can governments regulate humanitarian actors. In Haiti, particularly in the initial days and weeks following the earthquake, such regulation was not possible as the airport and border controls were severely damaged, leading ultimately to the abandonment of immigration controls.

Most respondents felt international standards would be useful to guide actors at least in the procurement and distribution of certain rehabilitation-related technologies. Currently, the only rehabilitation-specific guidelines are WHO guidelines on wheelchair provision[26] and P&O training[27].

Particularities of rehabilitation response

Difference between demand and supply

A theme emerging strongly from this study was the gap between services and technology needed, versus what was supplied by the humanitarian response in physical rehabilitation (such as PT and OT). This may be indicative of the influence that funders' priorities can have over programmatic decisions and the extent to which media reports influence funders' priorities. It is hard to ascertain the direction of causality, but worthwhile to note that study participants felt at times that provision in the sector was directed from outside Haiti rather than by the needs assessed in-country.

Prosthetics received the greatest attention in the immediate response although statistics from the HI/CBM/SEIPH Database indicated that amputations accounted for only 6% of the impairments recorded at the DVFP sites in 2010. Service provider interviewees expressed frustration with the inability to deliver orthotics services, when funding was restricted to provision of prosthetic services. A number of large prosthetic workshops was set up (or funded) by high profile European and American prosthetic companies. It was not possible, within the scope of this study, to determine what interest these companies had in working in Haiti but the phenomenon that was not commonly observed in previous disaster responses and it could arguably be attributed to Haiti's proximity to the USA.

Inappropriate technology

Our study highlighted the problem of the 'dumping' of inappropriate technologies in Haiti post-earthquake, including donated wheelchairs, distributed by NGO staff with little or no training in physical rehabilitation, so that beneficiaries received wheelchairs unsuited to their needs. This is problematic because use of inappropriately fitted wheelchairs can lead to severe (and even fatal) medical complications such as pressure sores[28].

This problem is linked with the previous discussion concerning international standards. Although the 2008 WHO guidelines on wheelchairs[26] are voluntary and are not yet adopted by Haitian government actors, agencies such as HI, CBM, and Motivation can use them to advocate for the establishment of minimum standards for the importation and distribution of wheelchairs in the country. Meanwhile, other areas such as P&O have yet to see the publication of international guidelines[r], and many study participants expressed the need for guidelines or standards to regulate the rehabilitation technologies permitted into Haiti. Thus, guidelines concerning appropriate technology for P&O services for post-disaster settings, professional skills for humanitarian actors providing rehabilitation services, and minimum standards for data collection in the field, would be warmly welcomed.

r Apart from the *Guidelines for training personnel in developing countries for prosthetics and orthotics services* (ISPO and WHO, 2005).

Clinical record-keeping and data collection

Another recurring theme in our results was the difficulty in maintaining adequate clinical (and other) records in the weeks and months following the earthquake. This can partly be attributed to working in a context with many immediate demands and a weak infrastructure, although it may also reflect the inexperience of many rehabilitation actors in humanitarian response. The more experienced actors (i.e. INGOs) seemed more cognisant of the need for solid record keeping and data collection.

Development of a standard data collection form and corresponding database tool that humanitarian actors in the rehabilitation field could download and reproduce for use in the initial emergency phase after any disaster, would reduce the amount of time spent by organisations developing their own forms, and would allow for compilation and comparison of data across agencies.

Blurred lines of responsibility

One difficulty in coordinating with Haitian authorities in the rehabilitation sector can be attributed to unclear lines of responsibility between the various government ministries. Disability-related issues usually fall within the remit of MAST and SEIPH (which receives its mandate from MAST but reports directly to the Office of the President). Meanwhile, physical rehabilitation is linked with medical services and would normally fall under the remit of the MSPP, especially regarding in-patient, and longer-term rehabilitation with significant medical concerns such as SCI care and management of diabetes.

Some respondents felt that MSPP authorities showed little interest in improving rehabilitation services in the national health system, despite examples of positive cooperation at district level[s]. Others felt that SEIPH overstepped its remit in some cases, for example in the distribution of mobility aids, which is not normally the responsibility of a governmental entity mandated to promote disability rights in State affairs. It was unclear whether SEIPH was assuming these additional responsibilities to fill gaps in services, or in order to be seen as providing desired services to boost public opinion of the Bureau (or the ruling party). It is hoped that in future SEIPH will take further action to encourage and assist the MSPP to fulfil its responsibility to increase and ensure access to rehabilitation services within the Haitian health care sector[t].

Beyond 2010

Each person interviewed shared their vision for the future of the rehabilitation sector and rehabilitation services in Haiti over the next 3–5 years. Participants in the feedback meeting held in Port-au-Prince in November 2011 also highlighted several more priorities.

s Examples in Northern Haiti came up in conversation with an SCI service provider.

t As required by Article 25 (Health) and Article 26 (Habilitation and Rehabilitation) of the CRPD. Haiti ratified the CRPD in 2009.

Training

Each respondent raised the issue of training for Haitian rehabilitation professionals as a high priority in the coming years: "What we want to do is introduce a post-registration rehabilitation accreditation certificate. Because there's so much rehab nursing out there that needs to be done! [...] It would be in conjunction with the Haitian nursing association"[21] .

Hopes for training include the post-registration rehabilitation accreditation certificate, rehabilitation technician training programmes – possibly to be co-coordinated between the Government of Brazil and the Government of Haiti – as well as a national P&O technician training, possibly in collaboration with University Don Bosco in El Salvador and Haiti[u].

Professional association

Professional associations play a crucial role to advocate for the recognition of professionals, the accreditation of diplomas, and the development of quality standards: "It would be very important that an association... unify all the PTs. Something like a college that has information on... how the sector is moving internationally and, for us, even though we are late, that doesn't mean that we cannot move forward to improve the life of the people with disabilities or people who are injured"[29]. These comments from a discussion with a Haitian physiotherapist and Haitian rehabilitation technician were echoed by an expatriate physiotherapist working for a different organisation and involved in developing the physiotherapy profession in rural Haiti for over 5 years: "It is promising to see consensus between Haitian and expatriate professionals regarding the formation of professional associations".

u For more information on current University of Don Bosco's current involvement in Haiti, see Healing Hands for Haiti's website: http://www.healinghandsforhaiti.org/OurWork/ProstheticOrthoticworkshop/tabid/73/language/en-US/Default.aspx (Accessed: 1 November 2011).

Growth of the sector and disability awareness

Beyond hopes and dreams for training, national certification, and the development of a professional body, respondents also saw the potential of the growing rehabilitation sector to transform Haitian perspectives on disability and people with disabilities.

Despite challenges in the sector, and continued lack of buy-in from the national Ministry of Health (at least as of May 2011), it does seem that the potential of rehabilitation services is increasingly recognised by health care professionals in the country: "The doctors will come up to me during our rounds and will say, 'I think this patient might need PT'... I think, 'Wow! Really?' It's great to see the doctors recognising that... just that awareness within the medical staff as well has been really great"30.

Therefore, despite frustrations in coordination amongst multiple actors with varying priorities, it will be important to watch Haiti's rehabilitation sector as it becomes more formalised, as training programmes develop, and as the services take their place within an evolving health care system.

6 Recommendations

1 **Improve** the cluster system coordination mechanism:

- The meetings should focus more on the future and what every actor should do to build the rehabilitation sector.
- Mitigate barriers to local actors' participation by conducting meetings in an accessible location, in the country's official language/s.
- Provide other options (email, phone or Skype) for receiving cluster updates and giving input to encourage participation by organisations unable to attend due to staff unavailability or geographical barriers.
- Develop a standardised form for collection of clinical and programmatic data from all rehabilitation actors in the disaster response. This should be available online and its use encouraged through the cluster system.

2 **Enhance** rehabilitation services as part of humanitarian response:

- NGOs, INGOs, and I/NGOs should ensure that staff (or volunteers) are aware of international standards for rehabilitation response.
- Rehabilitation professionals should have training in emergency response and/or experience in the affected country, before intervening post-disaster.
- Place greater emphasis on maintenance of solid clinical records and implementation of a strong data collection system from the very first hours of the response.

3 **Extend** the sustainability of rehabilitation services:

- After initial emergency-response phase, think about how a broad rehabilitation sector should be organised across actors and how resources need to be allocated to do so.
- As rehabilitation responses move from emergency to development phases, place increased importance on proficiency in local language and contextual awareness.
- Seize opportunities to increase the positive profile of people with disabilities and strengthen disability rights in the country through holistic rehabilitation services.

4 **Encourage** co-operation with local government and civil society:

- Organisations should prioritise hiring of staff proficient in the host language.
- Involve government and civil society stakeholders as early as possible in the development of rehabilitation services.
- INGOs and I/NGOs must budget the extra time necessary to involve local authorities. International organisations must be prepared to work more slowly than they may wish, if they seek to develop sustainable programmes.

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"The rehabilitation sector in post-earthquake Haiti was composed of a wide variety of actors, sometimes with conflicting approaches..."

Credits

Karl Blanchet and Myroslava Tataryn, Evaluation of Post-earthquake physical rehabilitation response in Haiti, 2010, ICED Research Report

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