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Haiti: tensions between aid relief and development in the health sector

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Since 2010 and the surge of aid on Haiti, the Caribbean island has undoubtedly become the symbol of the failure of major international programmes. For the three authors the emergency and development actors' conflicting objectives are one of the keys to this failure.

The need to bridge the gap between humanitarian relief and development programmes is now widely recognised[1]. However, this gap has been more present than ever before in Haiti. As medical anthropologist Paul Farmer points out:

"…disaster relief is not reconstruction. We haven't rebuilt Haiti despite giving 1.1 million people access to drinking water; we didn't remake the country with 11,000 latrines that have been installed. 'Building Haiti back better' means sustaining those temporary gains and adding education, health care, services, and good governance."[2]

However, the operationalisation of this policy faces practical hurdles. This contribution will explore the tensions between the emergency and development activities, with particular focus on the health sector in Leogane. The article's main argument is that the different activities related to humanitarian action have their own logic, and the enormous efforts invested in emergency activities have been detrimental to the overall goal of building a better, sustainable Haiti, with the final aim being to break the country's circle of dependence on the international community. Rather than pretending to have ready-made solutions for these very complex issues, the article aims to reflect and echo the tensions humanitarian intervention emergency activities have created on local structures and development programmes.

The article explores this theme by a precise focus on certain key elements of the "conflicting objectives"[3] applicable to the humanitarian/development assistance[4].

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[1] Oxfam, "Haiti: From Relief to Recovery. Supporting Good Governance in Post-Earthquake Haiti", January 2011, report available online in French and Creole: www.oxfam.org/fr/rapports/haiti-de-lurgence-au-relevement
[2] Paul Farmer, "5 Lessons From Haiti's Disaster", *Foreign Policy*, 28 November 2010, http://foreignpolicy.com/2010/11/28/5-lessons-from-haitis-disaster
[3] Sonja Grimm and Julia Leininger, "Not all good things go together: conflicting objectives in democracy promotion", *Democratization*, 19(3), 2012, p. 391-414.
[4] Roland Paris and Timothy D. Sisk, "Introduction: Understanding the Contradictions of Postwar Statebuilding", *in* Roland Paris and Timothy D. Sisk (eds) *The Dilemmas of Statebuilding: Confronting the Contradictions of Postwar Peace Operations*, London, Routledge, 2009, p. 1-20.

It is our hope that this article, inspired by interviews stakeholders carried out in the years that followed the earthquake, will enable practitioners and academics to reflect on the inherent limits of certain policies and mindsets, but also the incredible opportunities that exist for enhanced coordination between actors.

The challenges of Leogane's health sector

The epicentre of the 2010 Haiti earthquake, Leogane, is a commune of around 200,000 inhabitants located two hours from Haiti's capital. The city was severely damaged, with estimates ranging from 80 to 90 per cent of buildings destroyed in some neighbourhoods, including 60 per cent of the governmental, administrative and economic infrastructure[5]. Early estimates put earthquake casualties in the city at around 20,000 to 30,000[6].

Health services in Haiti are provided through four channels: public institutions, including State-run health centres and referral hospitals; mixed public and non-profit institutions, whose staff work alongside public employees; private, non-profit organisations, including institutions run by NGOs and church or faith-based organisations; and finally private, for-profit medical offices[7]. In that respect, the health system in Leogane is a microcosm of the global health system in Haiti.

Even before the earthquake, international aid accounted for over half of Haiti's GDP; a further quarter was from international remittances[8]. Estimates of the number of international non-governmental organisation (INGOs) operating in Haiti prior to the earthquake range from 3,000 to as many as 10,000, which led Haiti to be described as "the Republic of NGOs"[9] with the second-highest number of INGOs per capita in the world[10]. Furthermore, health care has been a constant priority for international donors. Between 2005 and 2009, 15 to 30 per cent of bilateral aid commitments to Haiti were earmarked for health and population programmes.

This lead to harsh criticism of humanitarians from Haitians that needs thorough ethical reflexion[11].

Similarly, the characteristics of the health sector before the earthquake need to be taken into account when evaluating distortions in the health response. Less than 5 per cent of the government budget was attributed to the health sector before the earthquake and around 40 per cent of the population had access to health services[12]; 75 per cent of them were delivered by NGO or faith groups[13]. The health sector in Haiti was underfinanced and loosely coordinated by the *ministère de la Santé publique et de la Population* (MSPP, Ministry of Health). A governance review

[5] We visited one hospital and one clinic severely damaged in Leogane. Both were not fully functional a year and a half after the earthquake.

[6] Lisa Millar, "Tens of thousands isolated at quake epicenter", *ABC News*, 17 January 2010, www.abc.net.au/news/2010-01-17/tens-of-thousands-isolated-at-quake-epicentre/1211748

[7] Keith Crane *et al.*, "Building a More Resilient Haitian State", *RAND*, 2010, www.rand.org/pubs/monographs/MG1039z1.html

[8] Denis O'Brien, "Haiti's Potential Waiting to Be Fulfilled", in "Build Back Better: Strategies for Societal Renewal in Haiti", *Innovations*, 5(4), MIT *Press Journals*, 2010, p. 7-11.

[9] United State Institute for Peace (USIP), "Haiti: A Republic of NGOs?", *USIP Peacebrief*, 26 April 2010.

[10] Daniel Trenton, "Bill Clinton Tells Diaspora: 'Haiti Needs You Now'", *The Miami Herald*, 10 August 2009.

[11] Jean-François Mattei, "Haiti, or humanitarian ethics under question", *Humanitarian Alternatives*, February 2016, p. 96-107, http://alternatives-humanitaires.org/en/2016/01/18/haiti-or-humanitarian-ethics-under-question

[12] Annie Kelly and Judy Roberts, *Is Haiti's health system any better?*, Merlin USA, Report, 2010, p. 3-20, https://reliefweb.int/sites/reliefweb.int/files/resources/213DD606ABE0EE328525781800702CD6-Full_Report.pdf

[13] Claude de Ville de Goyet, Juand Pablo Sarmiento and François Grünewald, "Health response to the earthquake in Haiti. Lessons to be learned for the next massive sudden-onset disaster", Pan American Health Organization, 2011, www.paho.org/disasters/index.php?option=com_docman&view=download&alias=2006-la-reponse-sanitaire-a-la-suite-du-tremblement-de-terre-en-haiti-janvier-2010-resume&category_slug=books&Itemid=1179&lang=en

of the health sector carried out by this Ministry in 2007 shows that leadership and regulatory functions in Haiti were "weak or very weak" at the central, departmental, and periphery levels[14]. One-third of the health infrastructure was public, but bad conditions, low salaries and lack of national coordination led many health employees to transfer from national to private or non-profit infrastructure before the earthquake[15].

The impact of free services on local structures

This massive international presence has raised and continues to raise numerous practical issues in Haiti. The relief phase materialised itself into a continuous flow of international workers coming to support emergency services and an army of INGOs coming to the bedside of Haiti's shattered institutions, turning Port-au-Prince and adjacent cites into wounded cities, "mobbed with rescue and relief workers"[16]. This international presence brought unintended consequences in the midst of the intervention. Two structural effects that the relief phase has had on the wider development perspective of Haiti will be specifically analysed here: the impacts of free services provided by international actors on Haitian health structures, and the wage inflation fuelled by the relief phase of the intervention.

One of the major debates surrounding international involvement in Haiti, and a fortiori concerning the massive relief effort, pertains to the provision of free health services by certain INGOs and its impact on the existing Haitian health system. In this context, there is an inherent tension in the provision of free health services – between the right to health and the "do no harm" approach. The right to health is clearly stated in humanitarian documents: "the right to health should be respected and protected. Amongst others the following activities can be considered, (…) providing free health services, in particular during the emergency phase"[17]. The right to health is a crucial component of the relief phase of international action. However, as will be discussed below, the right to health can bring unintended consequences to the local health system.

One of the principal elements of the "do no harm" approach is concerned with aid's impact on conflict through resource transfers. In the case of natural catastrophe in a country chronically dependent on international aid, we can observe the same perverse logic: do free services exacerbate dependence in post-earthquake Haiti?

This debate is very complex and cannot be addressed lightly. Officially in Haiti there is a system of exemption for the poor in the public structure. Unfortunately, this system is poorly regulated and the most vulnerable patients cannot always access it. Moreover, in these structures, medicines are often in short supply and need to be purchased in the private sector. This has a significant impact on health care access for the population of low-income countries such as Haiti and sub-Saharan countries[18]. There have been various systems to remove user fees fully or partially in low-income countries, but challenges to implementation have so far shown limited results[19].

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14 Claude de Ville de Goyet *et al.*, "Health response…", art. cit., p. 4.
15 Annie Kelly and Judy Roberts, *Is Haiti's health system…, op. cit.*
16 Paul Farmer, "Haiti After the Earthquake", *Public Affairs*, 2011.
17 Inter-Agency Standing Committee (IASC), "IASC Operational Guidelines on the Protection of Persons in Situation of Natural Disasters", January 2011, p. 35-36.
18 Frédérique Ponsar *et al.*, "No cash, no care: how user fees endanger health. Lessons learnt regarding financial barriers to healthcare services in Burundi, Sierra Leone, Democratic Republic of Congo, Chad, Haiti and Mali", *International Health*, 3(2), 2011, p. 91-100.
19 Bruno Meessen *et al.*, "Removing user fees in the health sector: a review of policy processes in six sub-Saharan African countries", *Health policy and planning*, 26. suppl 2: ii16-ii29, 2011. Valerie Ridde and Florence Morestin, "A scoping review of the literature on the abolition of user fees in health care services in Africa", *Health Policy Plan*. Jan 2011; 26 (1), p. 1-11.

There is no doubt that free health care services are saving countless lives in a context where the lack of access to health care for most of the population was already considered as "the forgotten emergency" prior to the earthquake[20]. There is a wide consensus that access to health services is much better since the earthquake[21]. Before the earthquake, only a few clinics provided the main health services in Leogane. There was no referral hospital as Sainte-Croix Hospital was not functioning properly and most patients went to Port-au-Prince for treatment or consultations.

The Chatuley Hospital, run by *Médecins Sans Frontières* (MSF), became by far the most important health provider in the area, conducting 4,000 to 6,000 consultations and up to 400 deliveries a month. According to many interviews conducted on the ground, local actors saw the MSF hospital as a positive addition to the region. MSF estimated at the time that half those benefitting from these free consultations would not be coming to the hospital otherwise. This estimate is corroborated by the MSPP Interim Health Plan, which states that 50 per cent of families say they do not have access to health care services because of the high costs[22].

Analysis of international action in this regard uncovers troubling issues. On the one hand, international bodies provide basic care services that were previously unavailable to many in Haiti. On the other, this action can prove destructive for the fragile Haitian health system, notably the private and mixed institutions. Local institutions found themselves in active competition with international ones. In that regard, the free provision of health services responding to the needs of the relief phase can reinforce the existing logic of dependence towards foreign assistance in mid- to long-term perspectives – that is, during the recovery and development phases of the intervention. According to Oxfam, free services (not restricted to health services) are having "a negative effect on the small Haitian private companies and individuals who traditionally provide many of these services. A number of clinics, schools, and small businesses have already gone bankrupt"[23]. This assessment is shared by RAND researchers who have conducted a far-reaching review of the post-earthquake situation in Haiti: "Free health services have been necessary to respond to the crisis, but the proliferation of free health care has resulted in several hospitals that rely on fees to operate shutting down [or having to reduce their activities]"[24].

However, in response to the negative consequences of free health services on local structures, the Haitian government wants the international organisations to start charging for medical services, something some NGOs are very reluctant to do. The plan is to gradually phase out free service and charge patients a larger percentage of the total fees[25].

Wage inflation and local tensions

The tension between emergency and development logics has also been fuelled by local wage inflation resulting from relief operations and tensions created by large numbers of volunteers arriving in the country after the earthquake. The influx of foreign doctors had at least one unintended consequence: "it caused many local private clinics to lose business, displacing Haitian

[20] Patralekha Chatterjee, "Haiti's Forgotten Emergency", *The Lancet*, 372 (9639), 2008, p. 615-618.
[21] Annie Kelly and Judy Roberts, *Is Haiti's health system…, op. cit.*
[22] Rony Brauman, "Haïti: La médecine privée et les privés de médecine", *Libération/Blog Issue de secours*, 28 July 2010, http://humanitaire.blogs.liberation.fr/2010/07/28/haiti-la-medecine-privee-et-les-prives-de-medecine
[23] Oxfam, "From Relief to Recovery…", art. cit., p. 12.
[24] Keith Crane *et al.*, "Building a More Resilient…", art. cit., p. 126.
[25] Patrick Adams, "Health Care Dynamics in Haiti", *The Lancet*, 376 (9744), 2010, p. 859-860.

medical professionals, who soon found themselves competing for patients in a marketplace dominated by volunteers"[26].

For Denis O'Brien, a well-known entrepreneur in Haiti, "as essential and valuable as INGOs are to the post-earthquake rescue and recovery efforts, we need to ensure they don't mop up all the most talented and educated staff or create wage inflation"[27]. Similarly, for *Le Nouvelliste's* editor Max Chauvet: "with their infinite and generous budget, medical INGOs have put in place a free and efficient health system, poaching in the process the executives who were making the private system work[28] [our translation]". Hence, until something changes, "the private Haitian medical sector will not be able to survive"[29]. For example, nurses working for the main INGOs are paid around $1,000 per month, compared to $300 or $400 when they were in the private system. Getting a job with an NGO was like winning the lottery for many.

In the context of Haiti, the extent of the human resources needed to support the INGOs' ambitions in the relief phase has disrupted some of the existing health structures throughout the country. Many actors we met mentioned the critical lack of human resources in the medical sector in Leogane. Hence, in this already insufficient health context, the relief phase of the 2010 international intervention has exacerbated tensions over local resources.

International structures provide opportunities that were simply non-existent in public structures, including gaining valuable experience by working with a variety of skilled national and international colleagues, and having access to training and quality medical equipment.

Some international NGOs have since expatriated some of their key staff. While it is a career opportunity for individuals, it contributes to the brain drain not that only affects private health structures, but the country's health service capacity overall. Hence, Haitian medical staff cannot be criticized for leaving underfunded local structures for international ones. However, by the same logic – perfectly reasonable and sensible – single decisions by many individuals turn into wider development challenges for the whole community. Lowering salaries for local staff hired by international agencies would send mixed messages to local counterparts, especially in a context dictated by comparatively opulent living and working conditions for international officials. Furthermore, lowering local salaries could potentially mean less motivation as well as a higher risk of corruption.

Lack of local partnership: the inclusion-exclusion dilemma

If the inclusion or poaching of local staff gave rise to tensions in Leogane, the exclusion of local structures in the decision-making process brought forth a whole set of issues. Partnership is an essential principle in humanitarian assistance, especially since it became the fourth pillar in the reform process with the creation of the Global Humanitarian Platform in 2007 and more recently part of the Grand Bargain[30]. However, this principle has not been translated into effective policy in Haiti and many international organisations limit their local partnerships to the participation of local actors (individual or organisational) to the implementing phase of their activities rather than

[26] *Ibid.*, p. 859.
[27] Dennis O'Brien, "Haiti's Potential Waiting to Be Fulfilled", *in* "Build Back Better: Strategies for Societal Renewal in Haiti", *Innovations*, 5(4), MIT Press Journals, 2010, p. 9.
[28] Max Chauvet, "Où en est Haïti un an après le séisme ?", *Le Nouvelliste*, 13 janvier 2011.
[29] Scott Farwell, "Haiti's Private Medical Sector Collapsing as Charities Rush to Provide Free Health Care", *Dallas Morning News*, 20 June 2010.
[30] The Grand Bargain is an agreement between more than 30 of the biggest donors and aid providers, which aims to get more means into the hands of people in need. See more details: www.agendaforhumanity.org/initiatives/3861

building meaningful collaborations from the beginning[31]. An important report on the health system in Haiti concluded that a more collaborative approach to disaster response is needed in order to "better support the long-term recovery of health systems"[32]. Consistent with the arguments presented above, this article argues that a collaborative approach needs to be implemented even during emergency activities.

The international perception prevailing in most international interventions following disasters is generally that of *tabula rasa* or "empty shell", where everything needs to be brought in from the outside[33]. In Haiti, "the assumption of many of the international teams was that local healthcare provision was non-existent or negligible"[34], in the process confounding Haiti's complex health system with its weak public health structures. The "we'll do it ourselves" approach was prevalent, as is usually the case in the aftermath of catastrophes. However, if an international actor engaged in the emergency relief effort waits until the end of its project to create local partnerships, these partnerships will most likely never happen, or will not be sustainable in the long run. Too many INGOs do not have specific partnerships with local institutions; however, there are several exceptions, including Partners in Health[35] or the Red Cross movement, which implements its programmes through national partners, in this case the Haitian Red Cross. At the same time, these partnerships respond more to the logic of reconstruction and development than to the relief logic in the strict sense, which makes it difficult for these organisations to include this priority following a natural or man-made disaster.

In practice, most capacity building and "local ownership" promoted by international actors in Leogane seems to have been related to their own local staff rather than Haitian structures per se. INGOs and semi-private actors hire local medical staff to work in their structures to varying degrees depending on the nature of the international actor and its need, strategy and commitment on the ground. From the international perspective, hiring local medical staff can have a positive impact on the training of local doctors and nurses. However, this restrictive vision of capacity building should not be confused with partnerships with local institutions. As mentioned, after more than a year in Leogane, most of the organisations had not instigated specific partnerships with local institutions. Certain organisations did not even try to create such partnerships, arguing that no local organisation had the capacity to complement their work. Other international actors would like to create such a partnership to hand over their clinic and services, but face the difficulty of supporting this need as a day-to-day priority for their own organisation. Finally, other actors are trying to make the transition to a more sustainable partnership, but it appears hard to cement partnerships after more than a year working within their own structures and priorities. Added to that are the sometimes conflicting priorities identified by different actors (local and international), and also the confusing role played by certain public officials with a personal stake in the development of the private sector. As demonstrated in short-term experiences in global health in many low and medium income countries (LMICs), the role of local engagement through partnerships is crucial to mitigate potential pitfalls.[36]

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31 Andréanne Martel, "La participation locale comme conditionnalité de l'aide ? L'expérience des camps de déplacés en Haïti", *Politique et Sociétés*, 34: 3, 2015, p. 9-36.
32 Annie Kelly and Judy Roberts, *Is Haiti's health system…, op. cit.,* p.3.
33 Nicolas Lemay-Hébert, "The Empty-Shell Approach: The Setup Process of International Administrations in Timor-Leste and Kosovo, Its Consequences and Lessons", *International Studies Perspectives*, 12(2), 2011, p. 190–211.
34 Annie Kelly and Judy Roberts, *Is Haiti's health system…, op. cit.*, p.8.
35 Laura Zanotti, 'Cacophonies of Aid, Failed State Building and NGOs in Haiti: Setting the Stage for Disaster, Envisioning the Future', *Third WorldQuarterly* 31(5), 2010, p.751-771.
36 Lawrence C. Low *et al.* "Short term global health experiences and local partnership models: a framework", *Globalization and Health*, 11:50, 2015.

The marginalisation of local actors during the relief phase has clearly led to a further erosion of local capacity[37]. It does not mean that the local actors have the capacity – or even sometimes the willingness – to single-handedly respond to and manage crises like the cholera outbreak in October 2010 or the January 2010 earthquake or more recently with hurricane Matthew in October 2016. However, marginalising local actors only creates resentment in the early stages of the intervention, with further potential difficulties for recovery and development activities. Moreover, local actors have something that is difficult to quantify in emergency needs assessments, which is cultural awareness – a specific understanding of the local socio-political context – as well as a long-term perspective on the issues they face. From the international perspective, the poor state of local infrastructure and certain structural limitations (corruption or perceived incompetence) have impeded them from working effectively with local partners. The local actors tend to see the problem from a reverse angle, pointing to the fact that initial marginalisation of Haitians works as a self-fulfilling prophecy, contributing to the further deterioration of Haitian capabilities and fuelling the brain drain phenomenon. Six years after the earthquake, hurricane Matthew demonstrated the importance of integrating community-based assets in being prepared for disasters as Haitians mainly rely on family networks and local forms of solidarity. These measures should also be embedded in other phases including the recovery and reconstruction ones[38].

At the same time, coordination between international actors and local partners has long been a contentious point in Haiti, even before the earthquake. The MSPP is nominally responsible for coordination, regulation and leadership of the Haitian health system, while at national level the Ministry of Planning and External Cooperation (*ministère de la Planification et de la Coopération externe* – MPCE) is mandated to coordinate and manage economic and social development planning. In that respect, the MPCE is the mainstay for coordination between external actors and the Haitian government. In reality, Haitian institutions do not have this capacity since the earthquake, and their capacity was clearly limited even before it. International actors like the WHO have clearly taken the lead by implementing what has been called the cluster approach. Local and international actors have also generally recognised that MSPP leadership is profoundly lacking in Leogane.[39] There seems to be a lack of motivation and resources to implement coordination on the ground. In this context, INGOs and local organisations have been very frustrated with the MSPP's lack of leadership.

Lessons

This contribution has highlighted different "unintended consequences" of emergency relief on the wider objective of development in Haiti. In doing so, we have zeroed in on the "conflicts of objectives" that seem important to keep in mind while devising policies and responses in the aftermath of crises, analysing the impact of the free supply of medical services on local health structures, the issue of wage inflation and the tensions created by the massive arrival of international workers, and finally the exclusion of local actors from emergency activities. Rather than pretending to have ready-made solutions for these very complex issues, the aim of the article was to reflect and echo the tensions created by emergency activities on development activities and local health structures. We suggest that all actors (local and international) need to understand the interplay between the various activities of the intervention. At the same time,

[37] Andréanne Martel, "Coordination humanitaire en Haïti : le rôle des *clusters* dans l'externalisation de l'aide", *Mondes en développement*, 165: 1, 2014.
[38] Louis Herns Marcelin, Toni Cela and James M. Shultz, "Haiti and the politics of governance and community responses to Hurricane Matthew", *Disaster Health*, 3:4, 151-161, 2016.
[39] Andréanne Martel, "Coordination humanitaire en Haïti…", art. cit.

crises, and the interventions that follow, are not doomed to have only negative effects on the development of the host society. We agree with Daphne Hemily that "there are opportunities that need to be recognized"[40], which include increasing the government's legitimacy, better access to international resources, and specialists that can bolster human capacity on the ground. In this regard, understanding the conflicting objectives of emergency and development activities is one step towards more effective and sustainable humanitarian interventions.

Biographies

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[40] Daphne Hemily, *Creating Opportunities From Crisis: Exploring the Potential for Post-Conflict Health Care Systems*, Lambert Academic Publishing, 2010, 39.