

PERSPECTIVE

Political Violence and Public Health in Haiti

Paul Farmer, M.D., Ph.D.

In 1991, a violent military coup unseated Haiti's first democratically elected government. An estimated 5000 people died, and hundreds of thousands more were displaced during the three years when military and paramilitary groups ruled the country. It was my privilege and responsibility to help provide basic medical services in central Haiti during those years. After constitutional rule was restored in 1994, it was possible to assess the effects of those events on our medical and public health efforts in the central plateau. We termed these years the "lost years," since many of our efforts required a modicum of order and a functioning public health system in order to bear fruit.

In the years since 1994, the nongovernmental organization Partners in Health has been able to forge strong public-private partnerships throughout central Haiti. During the past three years, for example, we have scaled up an integrated AIDS prevention and care project in this region. With support from the Global Fund to Fight AIDS, Tuberculosis, and Malaria, about 1000 patients with advanced human immunodeficiency virus disease are currently receiving supervised, community-based care and treatment. Working in conjunction with underfunded public health clinics, we were witness to the reinvigoration of primary health care in many of the major towns in central Haiti.^{1,2}

But recently, a long-simmering conflict in Haiti has erupted and threatens to reverse these important gains. There is no denying that Haiti's 33rd coup d'état brings an end to constitutional rule. As physicians and health workers, we must note that Haiti's only large public teaching hospital has been paralyzed by violence and dissent. For years, economic pressure resulting largely, though not wholly, from an international embargo on loans and aid has left almost nothing to invest in the care of the destitute sick. For a sense of how meager the health investments have been, consider the experience of an American doctor who commutes between a Harvard teaching hospital and a squatter settlement in central Haiti. Revenues for the entire Republic of Haiti, population 8.3 million, were less than \$300 million

in 2003. During the same year, revenues for a single Harvard teaching hospital — and there are 17 Harvard teaching hospitals — were pegged at \$1.3 billion. Most Haitians, the poor majority, simply go without modern health care even in the absence of political turmoil.

But this turmoil adds a special burden to both patients and providers. A long-standing dearth of funds for health care and other services, coupled with a rising tide of violence and mayhem, has led to the worst humanitarian crisis the region has known in decades. The past two months have seen a shut-down of services in much of Port-au-Prince. A recent report from the Pan American Health Organization (PAHO) offers little reason for optimism in the longer term:

The intensifying socio-political crisis in Haiti is having a negative impact on the health of the Haitian population. Haiti has the highest infant and maternal mortality, the worst malnutrition and the worst AIDS situation in the Americas. The general mortality rate was 1057 per 100,000 population during the 1995–2000 period, also the highest in the Americas. A quarter of the children suffer from chronic malnutrition, 3 to 6% of acute malnutrition. About 15% of newborns have a low birth weight. Acute respiratory infections and diarrheas cause half of the deaths in children under 5 years of age. There are complications in a quarter of the deliveries. The coverage of services is very low: 40% of the population has no real access to basic health care, 76% of deliveries are made by non-qualified personnel, more than half of the population has no access to drugs, and only half of the children are vaccinated.³

The report goes on to signal "disregard for the health institutions' neutrality and immunity" and notes that "several hospitals were the target of violence. Patients were assaulted in some institutions and the staff providing care is worried about exercis-



ing their duties safely. In some health institutions, the staff does not report for work on the day of demonstrations. Some of the patients in need of emergency care do not go to hospitals anymore for fear of violence. The Port-au-Prince University Hospital, one of the main hospitals in the country, has been almost at a standstill for weeks, for lack of personnel.”

PAHO also reports that “insecurity is highest in [the] Artibonite and Central” departments, or regions. Our own efforts are based in the Central Department, where I have worked and lived for more than 20 years. We know this insecurity well. Recently, three of our medical vehicles were commandeered — two in Lascahobas and one in Thomonde — by the heavily armed men who have once again assumed command as Haiti’s military leaders. Last May, the same men had stolen another ambulance and held five members of our medical staff hostage for several hours in the town of Péligré. They had already killed two night watchmen, both patients of ours, at the country’s only large hydroelectric plant.

These vehicles are crucial to the functioning of our hospitals and clinics, since trucking of medicines and other supplies to devastated central Haiti is the only means by which we can provide care effectively. Transport of personnel is also essential: the Central Department boasts no home-grown doctors, and our own medical staff is from Port-au-Prince or Cuba. There are fewer than 2000 doctors in the entire country, and most of them are based in Port-au-Prince, where less than a quarter

of Haiti’s people live. Haiti produces doctors, but its history of repeated coups and brutal dictatorships makes it next to impossible for the country to keep them. This problem is not new. Historians report that “in the decade following the 1957 ascent of Dr. François [“Papa Doc”] Duvalier to power . . . 264 physicians graduated from the state medical school, and all but 3 left the country.”⁴

In the past few years, however, three new medical schools have been established in this impoverished nation. One of these institutions, the University of Tabarre, has recruited medical students from poor families residing in all nine of Haiti’s departments. Talented young people from rural Haiti had previously found it nearly impossible to make their way to medical school, but this institution specifically seeks young trainees who are willing to make a commitment to returning to their home communities. Both creating essential opportunities and answering a desperate need, a new campus for this school was dedicated in December 2003.

Against all odds, even more progress was made. The teaching hospital of the University of Tabarre, to be shared with Haiti’s state university and its leading private medical schools, opened on February 6 in the Delmas area of Port-au-Prince. Less than 24 hours after the ribbon was cut, babies were being delivered in the safety of a modern medical facility — a rarity in Haiti, where maternal mortality rates are appalling. Even the low-end estimates (523 per 100,000 live births) are the worst in the hemisphere, and one community-based survey conducted in the mid-1980s pegged the rate at 1400 per 100,000 live births.

But good news rarely lasts long in Haiti: in early March, Haiti’s newest medical school was turned into a military base for U.S. and other foreign troops. What will become of its faculty, composed in large part of Cuban public health specialists but also including Haitian, U.S., and European teachers? More to the point, what will become of its 247 medical students? What will happen to the dean of that school, a Haitian surgeon who was trained in Germany? In short, what will become of the only medical school in Haiti whose top priority is the development of a cadre of physicians to serve the nation’s poorest and most vulnerable people?

Whether the presence of foreign troops will achieve a return to order in Haiti is not yet known. But so far the rebels who consider themselves the revived Haitian army include men who intimidate



Figure. Crowds of Sick Patients Wait Overnight for Medical Assistance in Haiti's Central Department.

Photograph courtesy of David Walton, Partners in Health, 2003.

doctors and nurses, deny medical care to the wounded, pillage facilities, steal scarce supplies and equipment, and are eager, for political reasons, to wipe out any and all legacies of Aristide, who founded the medical school and the teaching hospital. One would think that the desperateness of Haiti's situation would transcend politics, that hospitals should remain open to all those who need care, and that no training facilities should be closed. In the turmoil of rival factions and muddled loyalties that is Haiti now, the need for medical services should stand as an indisputable area of moral clarity.

Clearly, Haiti needs emergency assistance. Haiti, the oldest neighbor of the United States, is far and away the Western world's most impoverished nation. Yet official aid to Haiti has not been very substantial during the past decade. At the height of our involvement, for example, the United States was giving Haiti, per capita, $\frac{1}{10}$ of what it was distributing in Kosovo. Little of this aid passed through elected officials and government agencies. Over the past three years, almost all of the money went

to nongovernmental organizations, and some of it to the anti-Aristide forces.⁵ The funding cuts and diversion to the opposition precluded efforts to rebuild schools, health care infrastructure, ports, roads, and airports.

Today, we are reassured that experts in "complex humanitarian disasters" will henceforth manage aid to Haiti. But tardy and disorganized interventions will not undo a decade of misguided aid policies. Nor are piecemeal approaches focused on nongovernmental organizations likely to improve the basic health of the Haitian people. Robust public health requires a strong ministry of health, which should itself derive legitimacy from an elected government. The fates of a few thousand people living with AIDS in central Haiti may be determined by groups like ours, with or without our ambulances and other vehicles. We and our Haitian coworkers are proud of our work here. But millions of Haitians need basic health services, and these services will not be available without a stronger public health infrastructure, improved medical education, and an end to the po-

liticization of aid that stands as one of the most shameful chapters in international health.

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Disparities in Health Care — From Politics to Policy

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This first report clearly demonstrates that racial, ethnic and socioeconomic disparities are national problems that affect health care at all points in the process, at all sites of care, and for all medical conditions — in fact, disparities in the health care system are pervasive.

— *National Healthcare Disparities Report, as submitted to the Department of Health and Human Services (DHHS) by the Agency for Healthcare Research and Quality (AHRQ), July 2003.*¹

This first report finds that, while most Americans receive exceptional quality of health care and have excellent access to needed services, some socioeconomic, racial, and ethnic differences exist.

— *National Healthcare Disparities Report, as released by the DHHS, December 2003.*²

On December 22, 2003, as many Americans began their Christmas holidays, the DHHS released two comprehensive reports about health care, the National Healthcare Quality Report and the National Healthcare Disparities Report.² Four years earlier, Congress had passed a law requiring the AHRQ, which is part of the DHHS, to report annually on both the overall quality of health care and disparities in health care among racial and other groups.

It is standard procedure for government reports to go through a clearance process before their public release. The review may involve substantial back and forth among many officials, and it usually escapes public scrutiny. Moreover, federal reports,

particularly those that are released during holiday periods, often attract little attention. Within weeks, however, it became widely known that although the December report on disparities in health care contained essentially the same tables of data as the report that AHRQ officials had submitted for approval six months earlier, it otherwise differed markedly from the July version. Democratic staff members in the House of Representatives who work for Representative Henry A. Waxman (D-Calif.), the ranking minority member of the House Committee on Government Reform, called attention to these differences by making public an internal AHRQ draft of the executive summary from June 2003. They issued a report on the changes as “a case study in politics and science.”³

Members of Congress and others are more likely to read the executive summary of a detailed government report than the entire report. The June version of the executive summary of the National Healthcare Disparities Report and the July version, which AHRQ sent to the DHHS for approval, were similar but not identical. The first sentence of the July version stated that the report was “intended to provide a balanced summary of the state of disparities in the United States.”¹ By comparison, the narrative in the December version was substantially rewritten to downplay the negative and emphasize the positive, including areas in which “some ‘priority populations’ do as well or better than the general population.”² When these two versions are read side by side, the changes are evident both in the executive summaries and throughout the rest of the text. As