Assessment on the Psychosocial Needs of Haitians Affected by The January 2010 Earthquake

IOM International Organization for Migration

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Cover photo: Painting by IDP adolescents at Corail Camp and IOM artistic animator Mario Aristene

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Glossary of Terms

AAD	Adversity Activated Development
ACDI/VOCA	(International Cooperative Development Association/ Volunteer Development Corps)
ACF	Action Contre la Faim
ACSI	Associaton of Christian Schools International
ACTED	Agence d'Aide à la Coopération Technique Et au Développement
ADRA	Adventist Development and Relief Agency
AIR	American Institute of Research
ANOVA	Analysis of Variance
ARC	American Red Cross
AVSI	Association of Volunteers in International Service
CARE	Cooperative for Assistance and Relief Everywhere
CISP	Comitato Internazionale per lo Sviluppo dei Popoli (The International Committee for the Development of Peoples)
COCEQ	Comite de la Cour des Enfants de Quetsar
CRF	Croix Rouge Française (French Red Cross)
CRS	Caritas/Catholic Relief Services
DDC Cooperation Suisse	La Direction de Développement et de la Coopération
DINEPA	Direction Nationale de l'Eau Portable et de l'Assainissement
DTM	Displacement Tracking Matrix
ENS	Ecole Normale Supérieure
FBO	Faith Based Organizations
FHI	Family Health International
FPGL	Fondation Paul Gérin-Lajoie
FPN	Fod de Parrainage National
GJARE	Youth in Action for Reform
GoH	Government of Haiti
GRET	Groupe de Recherche et d'Exchanges Technologiques
HI – Haiti	Handicap International – Haiti
IASC	Interagency Standing Committee
IDEJEN	Initiative Pour Le Developpement des Jeunes
IDEO	Institut de Développement Personnel et Organisationnel
IDP	Internally Displaced Persons
IFRC	International Federation of Red Cross
IMC	International Medical Corps

IOM	International Organization for Migration
IRC	International Rescue Committee
ITECH	International Training and Education Center for Health
MHPSS	Mental Health and Psychosocial Support
MSF	Médecins Sans Frontière
MSH	Management Science of Health
NGO	Non-governmental Organizations
OCHA	Organization for the Coordination of Humanitarian Affairs
PAHO	Pan American Health Organization
Prodev	Progress and Development
PTSD	Post Traumatic Stress Disorder
RAP	Rapid Appraisal Procedures
SAJ	Société Jeunesse Action
SPSS	Statistical Package for the Social Sciences
UNCOR	United Methodist Committee on Relief
UNICEF	United Nations Children's Fund
URAMEL	Unité de Recherche et d'Action Médico Légale
WHO	World Health Organization
WV	World Vision

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Executive Summary

The 12 January earthquake which struck the Haitian coast, followed by several other aftershocks, has greatly damaged various cities in Haiti. At the end of August 2010, the government and humanitarian community estimated that over 2 million people had been affected, 222,570 individuals died, with an estimated 80,000 corpses still missing; 188,383 houses were destroyed or partially damaged, and 1.5 million persons were still displaced in 1,368 settlement sites (OCHA-Humanitarian Bullettin, 30th July 2010). Most of these families are still living in tents or self-made shelters constructed from tarpaulin and wood. Service delivery to these sites remains limited with the majority of efforts focused on addressing immediate needs in camps.

9,000 individuals only, identified as being at high risk of dangerous flooding, have been relocated to the only land identified by the government by the end of September 2010, while some land owners and schools have started evicting the displaced. Surveys have indicated that whilst some 40% of homes remain intact, many people are unwilling to return to their home or property due to both fear of another earthquake, and the fear of loosing the services currently provided in the camps (UNOPS- Safe Shelter Strategy, 14Th April, 2010).
Agencies working within the humanitarian cluster tasked with Shelter construction have provided 6,868 transitional shelters to more than 34,000 individuals up to September 2010 (OCHA Humanitarian Bulletin, 30 July 2010). The Government of Haiti is encouraging IDPs to return to their homes, but these efforts have so far yielded few results.

The Assessment on Psychosocial Needs of Haitian affected by the 12th January earthquake was conducted between May 2010 and August 2010. This assessment aims at analyzing the interconnectedness of emotional, social and cultural anthropological needs among the earthquake survivors in Haiti, and look at their interrelation at the individual, family, group and community levels, in order to provide viable information in the devising of multidisciplinary, multilayered psychosocial programs.

The assessment uses the Rapid Appraisal Procedures consistent with former IOM assessments.
The tools used include:

- A standard interview form for interviews with community's stakeholders
- A standard interview form for interviews with international stakeholders
- A standard interview guide, with discussion points for interviews with displaced families
- A list of self reported social conditions on 6 items: Housing, Security, Scholarization, Social Life, Food, Water and Sanitation.
- A list of distress indicators, encompassing 28 items.
- Focus groups*:* 2 focus groups with 20 Haitian families in 2 camps
- Interviews with stakeholders*:* 42 key informants, including international, national and local stakeholders.

Based on the Haitian cultural and anthropological considerations and the practical difficulty to interview individuals in camps without several members of the family participating, the current assessment was designed to be conducted in a family setting, allowing collective responses. Additionally the level of distress was not analyzed individually, but focusing on the recurrence of certain indicators across members of the families, with the ultimate intention to assess the wellbeing of neighborhood and its social and emotional determinants and not individual pathologies.

Quantitative aspects

This study was administered to nine-hundred and fifty families in displacement camps throughout Haiti. Analysis of the data showed that among the 950 families interviewed, families with parents and two children were the most common (26.7%).The principal respondents to the interviews, usually the household, were women in 60.4% of the cases (n=534) and men in the 39.6% (n=344) of the cases. The biggest number of respondents by far lives in Port-au-Prince (27%), followed by Petion Ville (17%) and Delmas (13%).

The average score of distress is 8.32/35 with headaches (74%) sleeping problems (60%), anxiety (56%), and fatigue (53%) being reported in more than half of the families interviewed.
The highest distress level scores were found in Leogane (10.8), Cit e Soliel (9.6), Delmas (8.9) Croix des Boukets (8.69), Gonaives(8.31) and Port au Prince (8.31) while the lowest in Grand Goave (3.0).

32% of the families stated that at least one of the respondents experienced at least one of the three major distress indicators (Panic attacks, serious withdrawal, or suicide attempts), with panic attacks being the most prevalent. There were only five cases, or 0.72% of the population, in which all three were experienced in the same family or individual respondent.

Results showed that the general level of distress is significantly correlated with poor access to food ($p= 0.039<0.05$) and more importantly with poor security ($p= 0.0001<0.01$). However, the other social indicators analyzed in this study (housing, scholarization, social life, water and sanitation) did not show a statistically significant correlation with distress.

60% of those interviewed stated they in a scale from I to V their level of pain is V.. The self-reported levels of pain are significantly and positively correlated with the respondents' composite distress score ($p=0.000< 0.01$).

Security (10%), unfamiliarity with location (9.8%) and sadness (nearly 10%) were the most common reported causes of uneasiness.

The most commonly reported definitions (idioms) describing pain are a need to *"Call to God," (33%)* The second most popular response is a feeling of the *"Pain and sadness*

drown[ing] me" (17%). Terms like *"Depression" (4.39%)* and *"Fear" (4.08%)* are least commonly used.

53.28% of respondents lost someone during the earthquake. Among those, 62.5% have lost one family member, 24% lost two family members and the remainder lost three or family members. A significant positive correlation was found between death in the family and level of distress ($p= 0.049 <0.05$).

Over a quarter of respondents reported that the family does not have any source of income, but income is not significantly correlated with levels of distress.

Less than half of the parents (48.7%) are able to send their children to school.

Respondents' most commonly self-reported needs were housing (>70%), health (61%), work (59.4%) and security (50.2%).

Lack of access to health and social services was reported in 45.7% of respondents and there is a significant correlation between locations and access to health and social services ($p=0.000<0.05$), better described in table 3 in annex.

To cope with unpleasant feelings, over a third of respondents go to a friend for help, 22.1% call on God and 20.8% go to the community health center. While, to respond to the family needs, close to 60% of those interviewed stated they struggled by themselves, 11.7% stated they would be willing to work in a low-paying job. In both cases none referred to services offered by NGO or IO in this survey.

Qualitative aspects

Looking at the housing and displacement conditions, the majority of the IDPs interviewed are living in camps, in sheet metal housing, wooden houses and tents and share their housing with other family members. Many complained about threat of eviction and restriction of movements, and the lack of safe spaces for children to play.

As for personal safety-security, people identify lack of the rule of law, presence of gangs and political unrest, lack of police patrolling and-or presence of corrupted police officers, overcrowding in the camps and gender sexually based violence as the main sources of concern. The possible reiteration of natural disasters, preventing many to leave the camps is another source of stress.

Results on the economic, family, social and recreational life shows that female-headed households suffer a sudden increase in the responsibilities they have to carry. They feel that after the loss or injury of their husbands due to the earthquake, they now have to assume the role as both "*mother and father*" for their children. While some households experienced the death of the primary income producer, other households had to deal with the fallout of an injured head of household. Many men feel emasculated because although

they are physically present in the household, they are unable to work due to their disabilities (most commonly an amputation). The relationship of parents with children was also affected as many families expressed that they cannot control their children anymore. Many families feel "*ashamed that they can't send their children to school"*, plus they think that lack of schooling is at the basis of the lack of structure in children's life, and the reason why some children now act like "*delinquents*." The children in exchange expressed the need to spend more time with their families and friends from school.
As for the enlarged family, according to the camps, respondents have praised the revival of Lakou system as one of their best protective achievements after the earthquake, or lamented the fact that the Lakou was dissolved or not considered in the organization of the camp.

Many respondents have lamented overcrowding, bringing to an unlimited and excessive need for socialization as a problem, and also a detriment to hygiene and health. Moreover people reported a more aggressive behavior in their neighbors and the population as a whole after the earthquake.
People who have experienced death in their family have higher level of distress, and qualitative results suggest that lack of proper passage rituals may be one of the main causes of this distress, related with guilt, preoccupations as to possible possessions, and retaliation from the ones, who did not receive proper burial. Lack of burial ceremonies in the past make the families unwilling to practice new rituals, like funeral or weddings due to the guilt they feel for non being able to conduct proper burial to the ones deceased during the earthquake

As to identify existing resilience mechanisms the results showed that the families usually refer to clergy, friend, prayers, community support, traditional remedies or community health centers. Families turn to God because, to many of the respondents, "*only He can predict the future"*, "*He is the only one to trust because He is the only one who knows the future"*. Some "*fear the future look to God for guidance*". It is also noted that for some "*all of our hope is placed in God*."
Most reported coping mechanisms used by kids to respond to sadness or frustrations are going to bed, play music, talk with enlarged family members or read. Their favorite games are football, play station, play with dolls, play with legos, card games, video games, racing, dance.
When asked to identify the main actions that could be taken to improve the overall wellbeing, the families mainly referred to employment opportunities and economic development, basic services and cultural conservation and recreational activities.
The children required to make a list of the most three precious wishes reported schooling, future and housing. Children and adolescent are concerned about the likeability to continuing their education, and being able to fulfill their dreams (becoming a doctor, a nurse, a psychologists, serve God, lawyer, pediatrician…).

The mapping of health and psychosocial services MHPSS in Haiti prepared by the IASC group revealed some significant gaps. These were mainly related to the overemphasis on

psychological responses (e.g. individual and group counseling) and the insufficient focus on social and community-based responses. In addition to that, there is a lack/insufficient provision of specialized services.

Organizations providing psychosocial and/or counseling services include:

- Local organizations: Centre de Trauma, Centre Psychiatrique Mars & Klien, Saj association, Haiti Tchaka dance, Plastimun, Kore Timun foundation, Group Intervention for children, Comite de la Cour des Enfants de Quettsar, Center Marie Denise Claude, Center D' Education Populaire, Partners in Health.

- International Organizations: IOM, ACF, ADRA, AVSI, HI, IFRC, MSF-Belgium, MSF-ES, MSF-H, Red Cross-France, WV, Red Cross NorCan ERU, MSF-Belgium, MSF-ES, MSF-Holland, Terre des Hommes, UNICEF, World Vision.

Recommendations

a) To enhance access to food in areas where distribution is not upon standards since this is a significant source of distress.

b) To enhance protective elements in the camps and prevent gender based violence. A reorganization of the camps across lakou lines, both in terms of the population allocated in them and the physical organization of the spaces in courtyards, could be a fast solution to the immediate problems of overcrowding, safety, protection towards GBV and other possible violent behaviors in the camps.

c) To provide safe, well lit spaces for socialization in the camps and structured activities.

c) To provide durable housing solutions, that won't undermine the economic and social life of residents due to distance from vital economic and cultural centers, and respectful of the Lakou system

d) To restore of a sense of legality and rule of law, possibly in a participatory community- based fashion.

e) To device and implement, in collaboration between communities, religious and traditional religious leaders of a Country dedicated ritual funerary ceremony, that could serve as definitive closure of the issue of proper burial of corpses.

f) To harmonize the available services and communicate their availability in a transparent fashion. It is recommended to establish or potentiate outreach-information teams, working in close collaboration with cluster and governmental systems, and with camp authorities.

g) To establish a newsletter for camp distribution and radio ads on available psychosocial services.

h) To establish a website of the humanitarian agencies' resources.

i) To respond to the long term outcomes of the current situation, building in service the capacity of the country to respond, through the establishment of an in service master program in psychosocial responses at the individual, family and community level, and the creation of a national expert team.

A part from the results of the study research, stakeholders formulated as series of recommendations that are summarized here below

- ***Culturally sensitive programs***: Haitians have strong attachment to cultural systems and values. MHPSS programmes should be community-based, family-focused and culturally-sensitive. The community should draw on their own resources to guide and lead MHPSS programming for sustainability
- ***Avoid duplication of services***: Organizations are concentrating on the same activities like child friendly spaces and group responses, and in the area of Port Au Prince. Thus brings to duplication as well as produces several gaps, both geographical and in the services provided.
- ***Mental health Structure***: Many organizations are concentrating on psychosocial support and neglecting specialized mental health services. There is need to develop specialist psychiatric services for referral, and encompass traditional practices and trans-cultural models in the services.
- ***Integration of mental health in health***: Mental health should be integrated with other medical outreach services. People living in areas hardly hit by the earthquake are suffering from all kinds of lingering maladies such as lost limbs, broken legs, eye and ear injuries as well as head injuries thus a need for integration to meet these health needs exists.
- ***Integration of livelihood within psychosocial programs***: Integration of the psychosocial and livelihood programmes is advocated. MHPSS programmes are successful when invested within rebuilding local economies. On the other hand, MHPSS programmes provide a multiplier effect on livelihood programmes.
- ***Child Protection****:* child protection is to be included in any psychosocial structure due to vulnerability of children and their situation in the country even before the earthquake.
- ***Maintain mobile teams***: Maintaining mobile clinics that address health isuues, others addressing mental health issues, and psychosocial mobile teams due to lack of physical structures mainly in suburb and faraway communes.
- ***Introducing psychosocial support modules in all primary and secondary schools***, in addition to specialized courses (on psychosocial response in emergency settings) at universities to enhance local capacities in responding to emergencies.
- ***Launching awareness campaigns*** regarding the importance of mental health and psychosocial support/ wellbeing.

I. INTRODUCTION

The 12 January earthquake which struck the Haitian coast, followed by several other aftershocks, has greatly damaged various cities in Haiti. At the end of August 2010, the government and humanitarian community estimated that over 2 million people had been affected, 222,570 individuals died, with an estimated 80,000 corpses still missing; 188,383 houses were destroyed or partially damaged, and 1.5 million persons were still displaced in 1,368 settlement sites (OCHA-Humanitarian Bullettin, 30th July 2010). Most of these families are still living in tents or self-made shelters constructed from tarpaulin and wood. Service delivery to these sites remains limited with the majority of efforts focused on addressing immediate needs in camps.

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Psychosocial Wellbeing and Mental Health in Emergency Displacement

Displacement due to natural disasters requires major adaptations, as people need to redefine personal, interpersonal, socio-economic, urban and geographic boundaries. This implies a redefinition of individual, familiar, group, and collective identities, roles and systems, and may represent an upheaval and a source of stress for the individual, the family and the communities involved.

Natural disaster-related displacement is accompanied by several stressors that include economic constraints, security issues, breakdown of social and primary economic structures and consequent devaluation or modification of social roles, and loss of loved ones. Moreover, instable and precarious life conditions, including difficult access to services together with the loss of one's own social environment and systems of meaning, and gaps in the rule of law, all contribute to create a very uncertain future.

Often these elements bring about a series of feelings, including grief, loss, and guiltiness towards the people who did not survive or other members of the family, a sense of inferiority, isolation, sadness, anger, angst, insecurity and instability. These reactions

caused by objective stress factors are generally not of psychopathological concern, and only in a very limited number of cases evolve in post-traumatic occurrences, making people unable to function (IASC 2007). However, providing psychosocial assistance in educational, cultural, community, religious and primary health setting aims at reducing psychosocial vulnerabilities and preventing their standstill which may in turn result in long-term mental problems and social dysfunctions (EU 2001; IOM, 2010).

This assessment aims at analyzing the interconnectedness of emotional, social and cultural anthropological needs among the earthquake survivors in Haiti, and look at their interrelation at the individual, family, group and community levels, in order to provide viable information in the devising of multidisciplinary, multilayered psychosocial programs.

The Haitian Context

No comprehensive psychosocial needs assessment was conducted in Haiti in the months following the disaster, due to capacity constraints and the impossibility to derive credible statistical results, given to the interrelation of too many factors. However, IOM conducted in the immediate aftermath of the event a very qualitative evaluation of psychosocial needs, resilience factors to respect and facilitate, and developments activated by the adversity on which to build the psychosocial responses on the individual, family, group, and community levels, through brainstorming with community leaders, academics, students of psychology, religious leaders, mental health and psychosocial professionals. This process involved around 200 individuals of both sexes- aged 22 to 82- many of which living or operating in camps. The instrument used was an adaptation of Renos Papadopoulos' systemic grid (Papadopoulos, 2002). The main results are categorized in chart 1.

Outline of consequences and implications (adapted from Renos Papadopoulos)

	Suffering Depression, anxiety Ordinary human suffering Default consequences	**Resilience**	**Adversity's Activated Development**
Individual	a) non clinical depression c) anxieties d) powerlessness e) fears for the future socioeconomic life f) fears of another disaster g) guilt towards the dead h) guilt towards the community i) guilt driven by the belief that the disaster was a punishment from God or Lwas l) sense of anger and frustration due to the poor services received and the disinformation about settlement plans	a) religion b) refer to the collectivity of the experience c) getting organized to help the others d) reviving social life e) creative activities, including ritual dances and songs	a) renewed sense of being part of a collectivity b) personal organizational and solidarity skills c) stronger coping mechanism than expected
Family	a) loss of loved ones b) separation and abandonment c) challenges to traditional family roles d) hyper-protection of children e) increase in stress and violence f) loss of belongings and memories	a) revival of family support and lakou systems b) trans-generational support c) solidarity d) sharing of emotional experiences within the family e) neighbourhood support	a) increased trust b) increased sensitivity and listening c) increased respect d) increased physical nurturing
Group identified as religious congregations, neighbourhood and colleagues)	a) withdrawal b) confusion c) disorganization d) loss of members of the group e) disorientations	a) sharing experiences b) religious rituals c)intellectualization/rationalization of the experience d) activation to help the others	a) a more participatory approach to group leadership and decision making b) new spontaneous affiliation c) groups becoming more inclusive d) community based security systems organized
Society	a) loss of lives, leaders, experts b) destruction and loss of cultural heritage c) enhancement of the "aid culture" d) pollution and poor environmental health e) fears and paranoia related with the presence of foreigners, especially in relation to cultural colonialism and political control f) redefinition of geographical and urbanistic boundaries g) Exacerbation of existing socio-cultural divides and fears of future social tensions.	a) hope b) religious beliefs and explanatory models c) aid d) referral to cultural and artistic life e) banalizing the experience	a) stronger national sense b) more critical political sense c) acknowledgement of the necessity to reconstruct better than before, on multiple levels d) reciprocity e) solidarity f) increased sense of community responsibility g) increase in volunteerism

On the individual wound level, the informal reports collected from IOM, IMC, Hi Tech, MdM, IFRC and other agencies, which have acted since the aftermath of the disaster on providing specialized mental health services, would suggest an epiphenomenal incidence of post traumatic reactions of clinical concern. The outpatient psychiatric clinic Mars and Kline in Port Au Prince received in the first 6 weeks after the events every day an estimate of up to 100 cases (IMC, unpublished) with different problems including epilepsy, pre-existing disorders but also anxieties, or medical problems of unknown causes, such as possibly psychosomatic reactions. IMC which was operating in the above-mentioned hospital as well as in additional six clinics identified through its very qualified psychiatric staff less than 50 severely distressed cases only, in 6 weeks of activity. IOM psychosocial teams, active in 19 camps, referred for specialized services 14 individuals only in the first 4 months after the disaster. In both cases, these were mainly pre-existing psychiatric cases, or females subject to individual assaults, and severely physically traumatized individuals, including people suffering from amputations and burns.

The participants' generated responses to this initial brainstorming validated from a field perspective relevant outcomes of the literature review conducted by the McGill University soon after the disaster (McGill, 2010). Since some of these findings inform the rationale, items and methods of the current assessment, they are listed below.

Family and lakou

Family is of primary importance in the Haitian social system (Craan, 2002; Nicolas, Swartz et Pierre, 2009, Mc Gill 2010), and is more flexible and extended than in Western societies, encompassing far family members, several generations, neighbors and friends. Prior to the 20th Century, and still today in the most rural societies, families were organized around the lakou, which defines both the courtyard around which the members of an extended family live, and the extended family itself (Nicolas, Schwartz, et Pierre, 2009, Edmond, Randoplh et Richard, 2007). While this concept has been challenged in the last Century, and especially after the Eighties by massive urbanization, migration, disaggregation, the anthropological dimension of the lakou is still at the fundaments of Haitian society (Mc Gill, 2010). Urbanized communities, by instance, tend to recreate it, as much as possible in the urban suburbs, and include people coming from the same rural districts in it. The same happens among University students moving to PauP to study. Most of the respondents to the initial brainstorming highlighted the revitalization of the lakou system after the earthquake as one of the main resilience factors, and this is trivially evident in the camps, since camp inhabitants tend to create aggregations across lakou lines.

Based on these anthropological considerations, and the practical difficulty to interview individuals in camps without several members of the family participating, the current assessment was designed to be conducted in a family setting, allowing collective responses. Additionally the level of distress was not analyzed individually, but focusing on the recurrence of certain indicators across members of the families, with the ultimate intention to assess the wellbeing of a neighborhood and its social and emotional determinants, and not individual pathologies.

Religion and the concept of identity

Religion plays a crucial role in the definition of individual and collective identities in Haiti, and in providing explanatory models to natural disasters. As such it was reported as a crucial resilience and response factor by the respondents to the first brainstorming. 80% of the population self define as Roman Catholics and 20% circa as Protestants, but people from lower classes, and therefore the big majority of the camps inhabitants are likely to adhere exclusively, or in combination with the other religions to Voodoo (Gopaul McNicol et ali, 1998; McGill, 2010). The Voodoo is considered as a religion because it is based on rituals, ceremonies and acts through which the individual enters in a relation with the divine. It is only in 1911, that the long standing practices of Vodoo were etymologically related to the concept of vodun, that is "god", a "spirit" or its "image" among the Fon tribes of Dahomey and Togo(Materaux, 1958). Hougan, the Vodoo celebrator, in Dahomenyan means "master of God". (Fils-aimé 2007).

Consistently with Vodoo beliefs and practices, identity in the Haitian traditional culture is anthropologically characterized by a cosmos-centric rather than anthropocentric vision of the self. Wellbeing results indeed form the harmony that an individual is able to create with his her context and the natural world, which encompasses a multitude of spirits, ancestors, and materializations of the so-called "invisible" (Brodwin, 1992). The brainstorming's results highlighted how the challenges brought to the individual identity by the natural disaster, are in fact mitigated by the collective fashion of the experience and its adherence to a natural cycle. Consistently, the current assessment looked at challenges faced by the population on the individual, family and community level, and at identifying existing explanatory systems and collective resilience factors.

Grief and other determinants of uneasiness

In the first brainstorming, death of significant others was not reported among the main causes of individual distress, but it became a significant challenge in the family and societal wellness, mainly due to the death of reference persons.

A possible explanation can be found in the fact that in Vodoo the world of spirits, ancestors and deceased is strictly linked with the world of the living. The *lwas*, such as the spirits of the African ancestors, divided in Ginen (the positive lwas), Rada, and Petros (the fighting spirits, including Makaya and Bumba) in fact directly influence the social and emotional wellness of families and individuals, as the spirits of the deceased family members do. The relation that exists between the *Lwa* that possesses a human and the human himself is that of "the horse rider and his horse", as in the popular saying "The Lwa seized his horse" (Metraux 1958). Moreover, practices of white and black magic include the possibility for Vodoo practitioners to revive the *zonbi* (soul) of dead persons, either in the form of living corpses or sending the air or the soul of the deceased to possess an individual, who will therefore assume characteristics and behaviour proper of the individual the air or the *zonbi* belonged to. Through the use of clay urns, called *govi*, the voodoo practitioners can also establish a connection and communication between the living and the dead.

Such a close emotional and affective relation between the world of the living and the one of the dead, may reduce the distress provoked by grief and make death of significant others an acceptable experience on an individual level. Therefore, and consistently with a psychosocial approach, this assessment did not imply a default relation between distress and magnitude of the losses due to the earthquake but analyzed the levels of distress with magnitude of the losses as well as problems of the present, including de-location, food provision, type of housing, security in the camps and socioeconomic status, to try to identify what predicts the most.

Determinants of access to mental health

Half of the Haitians do not have access to formal healthcare (CCMU, 2006). The rural population mainly accesses primary health care through faith-based NGOs and traditional healers. Among all classes, emotional matters, and psychiatric uneasiness are dealt within the family or the religious context. Lower class Haitians will generally seek help from *houngan*, and a mental health professional only if behavior is already unacceptable for the context. Upper class Haitians are more likely to refer to a combination of herbalist care and prayers (Mc Gill, 2010)

More serious forms of depression among the lower classes are likely to be associated with spell or possession. In these cases, Vodoo practitioners are involved and community ceremonies are celebrated to heal the possessions. If the person is freed by the spirit, he-she can be initiated to the Vodoo priesthood. Therefore possession may bring to a higher level in society and the discrimination between the person and the possessing spirit brings to the attribution of the "problem" to the entity and not to the individual, reducing stigmatization.

Prior to the last disasters, western psychiatric and psychological concepts of mental health have not been priority for the Haitian government, neither have been popular among the population, and a national mental health strategy is missing. 11 to 20 psychiatrists are accounted in the Country, of which 7 working for the public sector (PAHO, 2010), and 2 psychiatric hospitals exist in Port au Prince, the Mars and Kline for acute cases, with a capacity of 100 beds, and the Defilee de Beudet for mainly chronic cases, with a former capacity of up to 180 beds, and a current capacity of 50 transitional shelters constructed by IOM.

In this respect, the assessment tried to be respectful of existing belief systems, avoiding pathologization in the rational of the study, the semantic the terminology adopted and in the interviews procedures and setting.

II. METHODS

The assessment was conducted between May 2010 and August 2010, with the aim to identify the general level of distress in the population, to highlight its possible sources and list existing coping mechanisms to enhance and support. The quantitative part of the assessment in particular, tried to prioritize locations and thematic sectors of intervention, based on the correlations between levels of distress, geographical distribution and certain social indicators.

Objectives

The assessment objectives are a) to provide all humanitarian actors with information and insights that can make them more psychosocial sensitive and aware, while providing assistance, and b) to help psychosocial professionals to conceive specific psychosocial programs targeting the psychosocial conditions of internally displaced Haitians. More specifically, the study aims at identifying correlations of distress with geographical locations and social conditions, and to qualitatively look at existing coping mechanisms and possible responses.

Study type

Logistical and capacity constraints made it impossible to conduct a detailed assessment. It was therefore decided to use Rapid Appraisal Procedures for the following reasons:

- *Consistency with former IOM assessments*. The assessment on "Psychosocial Status of IDPs Communities in Iraq" (IOM; 2006) brought to the elaboration of appropriate assessment tools, which were readapted for the current assessment. The same tools were successfully re-adapted and used for an assessment on the "Psychosocial Needs of Displaced and Returnees Communities in Lebanon Following the War Events", (IOM; 2006), the "Assessment on Psychosocial Needs of Iraqis Displaced in Jordan and Lebanon" (IOM, 2008) and smaller scale initiatives in DRC and Kenya.
- *Flexibility*. Relying on multiple sources whose weight may vary according to the circumstances, it guarantees a wide degree of flexibility, within a scientific context.
- *Relevance*. Its approach is holistic and includes evaluation of existing initiatives in the field. In addition, it gives importance to local knowledge including the beneficiaries' evaluation of the situation. The RAP approach is likely to avoid prejudgments of the situation under analysis.
- *Participatory process.* It allows interviewers to contribute in the process of reviewing and adapting the tools, according to their understanding of the specifics of the local community.
- *Rapidity*. It allows conducting a scientific based assessment in a limited period of time, and allows a qualitative as well as quantitative analysis of results. This last

element is crucial, given the combination of large numbers of displaced, and a limited budget, which would make a large scale quantitative survey impossible.

Tools

The tools include:

A standard form for interviews with community's stakeholders and a standard form for interviews with international stakeholders.

Both interviews aim at receiving information on 1) the local understanding of psychosocial concepts and related response systems 2) existing psychosocial trainings, services and activities; 3) the stakeholders' perspective on priority needs of displaced Haitians; 4) stakeholders' plans and suggestions concerning strategies to be implemented. All questions are open ended, and the results are read in a qualitative way.

A standard interview, for displaced families.

The 57 questions are clustered on eight groups: living conditions, household list, families' understanding and definition of psychosocial needs and concepts, the family's view on existing coping mechanism, and their evaluation of the provision of services, psychosocial needs self-assessment, response, including suggestions for future programming and finally a focus on children. The questions and items, originally developed by IOM, were reviewed 3 times by a global interagency committee, by professors of the faculties of Human Sciences and Ethnology of the University of Haiti, and by the group of Haitian practitioners, who participated to a training of trainers (ToT) in Port Au Prince, to guarantee cultural and interagency appropriateness. The questionnaire is compiled by the interviewer thanks to a guided discussion with the interviewees, during which questions don't have to be responded chronologically. The discussions are conducted with all members of the families, who are willing to participate. However, for each question one response only is to be agreed per household. The questions are both closed and open ended and are read both in a quantitative and a qualitative fashion. In particular, the most recurrent answers to certain items were computed to analyze descriptive statistics and possible correlations with the items below.

A family well-being list

A measure quantifying the self-reported satisfaction on 6 basic social conditions: Housing, Security, Scholarization, Social Life, Food, Water and Sanitation, is compiled by the interviewer while discussing with the family (Annex IV)

1. **Housing:** For housing the family is asked whether they are residing in their own house, in a rented one , in a hosting family's house, in a shelter, in a tent in camp or in a tent within the property of a hosting family or put in the neighborhood.

Only one response option is allowed and each type of housing is numerically defined and computed.

2. **Security:** Each family has to state if they face one or more issues among: fear of disappearance of children; fear of rape; fear of being robbed; fear of being relocated; fear of ghosts; fear of dark; fears due to absence of police-rule of law. The sum of indicators is derived and tabulated.
3. **Scholarization of children:** is an objective indicator, respondents have to answer by yes or no.
4. **Social life:** the family can choose as many of the following items: we are in contact with our original community, we attend to church-ceremonies, one or more members of the family volunteer, one or more members of the family provide income, we socialize with peer groups or friends at least once per week. The sum of items is computed and tabulated.
5. **Food:** The family would state how many meals they eat a day on three measures: less than one meal per day, one meal per day, or more than 1 meal per day.
6. **Water and sanitation conditions:** are also addressed during the interviews with the families. The respondents are asked questions on access to water and sanitation facilities, and the general cleanliness of their camp, or settlement of residence. The sum of responses is tabulated.

A distress' indicators list

The list of 28 distress indicators (Annex IV, C) aims at measuring the level of distress in each household interviewed. As such it does not measure individual level of distress or pathological threshold of symptoms but just give an indication of general level of distress present in a family or neighborhood. In fact, it is compiled by the interviewer, who tackles a symptom whenever this is self attributed or attributed to another member of the family by a participant to the interview. It is designed based on the one used by the Italian NGO Movimondo in a previous mental health survey in Iraq(movimondo, 2004) and readapted based on the inputs of professors from the Faculties of Human Sciences and Ethnology of the University of Haiti and participants to the training of trainers (ToT). For the Distress indicators' list, using the response options to all 28 indicators, a composite distress score is calculated. All except three indicators are scored as 0 if the specific distress type is absent, and 1 if present. Three of the indicators, *panic attacks, suicide attempts, and withdrawal 2,* (3 factors identified by WHO for immediate referral) are given a value of 4 instead, if present. The number of one-point and four-point distresses was tabulated in order to get the composite score. The values varied from 1 to 35.

Focus groups

2 Focus groups were conducted with 20 Haitian families in the Terrain Acra and Tabarre Issa camps. The same questions as in the family interviews were presented but discussed in group settings. Answers were read only qualitatively and merged with the ones of the family interviews.

Sample

Interviews with stakeholders:
Interviews with 42 key informants, including international, national and local stakeholders and professionals (ANNEX II for complete list) were conducted by 2 experts. Stakeholders to be interviewed were selected following a relevance criterion and a snowball approach. A proportion was kept between professionals, community and religious leaders, authorities, International Organizations, and local NGOs officials.

Interviews with families, family wellbeing scheme, distress' indicators list:
Interviews with 950 displaced Haitian families were conducted by 76 interviewers
The sample was randomly selected among the population of 100 settlement locations, based on 2 criteria

(i) Pre existing relation of trust between interviewer and target group;
(ii) No existing direct help relation (direct provision of material help) between the interviewer and the interviewee.

Two focus groups
Focus groups were conducted with 20 Haitian families in total for a total of Number of 45 individuals aging from 19 to 55 years old. The families were chosen randomly.
.

Consent

Consent was provided verbally, and reiterate after the completion of the interview. Compiled forms are secured in a locked cabinet at IOM Health unit office.

Data Analysis

Not all 950 participating families answered to each question of the interview. Thus, for a number of questions, the responses were lower than the number of questionnaires administered. The total number of responses (N) for the question will be stated in each graph, table, and figure. The social indicators and the distress indicators lists were analyzed quantitatively, while the responses to the family interview were analyzed both quantitatively and qualitatively. Results of focus groups and interviews with stakeholders were analyzed qualitatively

Simple descriptive frequencies were measured for all items on the interview guides, family wellbeing scheme and distress indicators list. Selected variables and other responses from the interview questionnaires as well as the family wellbeing scheme, including income, location, educational level, number of children were compared with the composite distress variable and an analysis of variance (ANOVA) and/or a Pearson's test, to look for significant interrelations. Only correlations of 0.05 or lower were deemed

to be significant. The statistical analysis used IBM's Statistical Package for the Social Sciences (SPSS).

The qualitative analysis consists in an overview of the responses of stakeholders and IDPs to the questionnaire, and non-formatted focus group interviews. The responses were clustered into relevant themes in relation to objectives of the psychosocial assessments. The responses were used in order to flesh out some of the figures as well as give voice to some of the respondents' reports not fully grasped by the quantitative analysis.

Field work: Interviewers

Interviewers were selected among staff, volunteers and activists referred by the collaborating agencies. In total, 76 interviewers were recruited (30 from IOM psychosocial mobile teams and 46 from Action Contre la Faim, Adventist Development and Relief Agency-Haiti, Centre d'Education Populaire (CEP) et Enfants du monde et droits de l'Homme,Centre Marie Denise Claude, Comité de la Cour des Enfants de Quetsar, Fédération Luthérienne Mondiale, French Red Cross, Handicap International, Hosean International Ministry, Médecins du Monde Canada, Plan-Haïti, Save the Children, Société Jeunesse Action, World Vision). Out of these, 28 were women and 48 men, 74 were Haitians and 2 not Haitians with the professional background of Psychologists, Social workers, Nurses, Sociologists, Anthropologist, Educators, Animators. Interviewers received a 3 days training in psychosocial awareness, approaches, and assessment methodologies. During the training the assessment tools were re-elaborated according to the cultural sensitivity, the knowledge of the caseload, and the logistic constraints presented by the interviewers. Moreover the interviewers received a one-day debriefing on the assessment's provisional results.

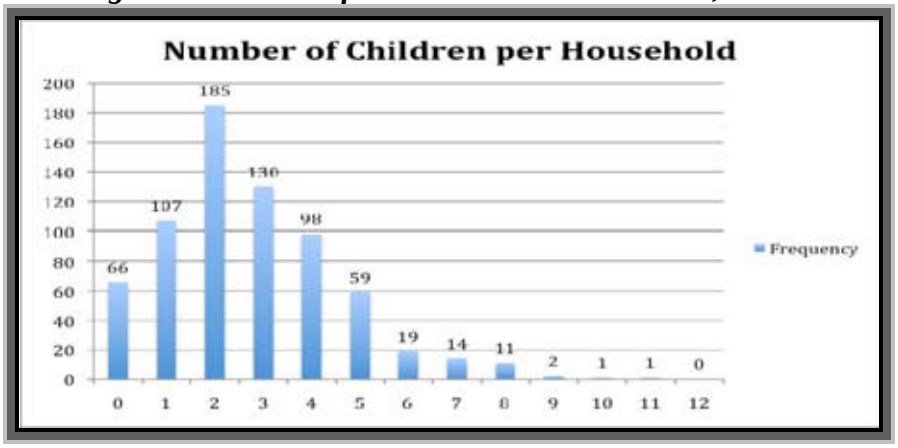
III. RESULTS

Population's descriptive statistics

950 families were interviewed for the survey, for a total of 950 surveys. Participants to each family interview varied from a maximum of nine members to a minimum of 3 members. However each family group of interviewees had to agree on a most relevant answer to be accounted to as the family answer.

Among the 950 families interviewed, families with parents and two children were the most common (26.7%) – Figure I.

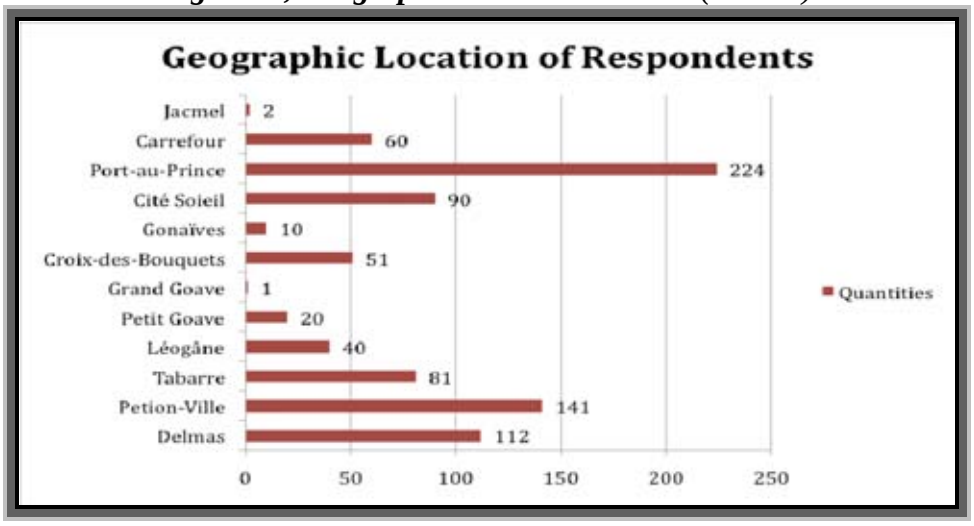
Figure I: Number of Children in the Household, N=693



The principal respondents to the interviews, usually the household, were women in the 60.4% of the cases (n=534) and men in the 39.6% (n=344) of the cases.

The biggest number of respondents lives in Port-au-Prince (27%), followed by Petion Ville (17%) and Delmas (13%) (Figure II).

Figure II, Geographic Location *(N=832)*



A) Scheme for Distress

The average score of distress is 8.32/35, with headaches (74%), sleeping problems (60%), anxiety (56%), and fatigue (53%) being reported in more than half of the families interviewed.

Table I Prevalence of Distress Indicators among Haitian Subjects 2010 *(N=693)*[1]

Distress Indicator	Reported prevalence
Headache	73.9%
Sleeping Problems	60.0%
Anxiety	56.3%
Fatigue	53.1%
Memory Loss	44.0%
Tachycardia *(accelerated heart rate)*	43.9%
Weight Problems/Appetite Problems	43.6%
Nightmares	38.4%
Hypervigilance	33.9%
Somatic Complaints	30.0%
Aggressiveness/Rage	28.4%
Panic Attacks	24.5%
Fear	21.4%
Flashback	20.3%
Learning Problems/Lack of Concentration	16.7%
Hyperactivity	15.3%
Isolation	12.0%
Withdrawal I	11.8%
Impotence/Loss of Menstruation	10.7%
Violence	9.2%
Suicide Attempts	8.8%
Culpability	8.4%
Substance	6.6%
Detachment	6.5%
Fits, Compulsion, Seizures	5.6%
Withdrawal II	3.9%
Bed Wetting	3.3%

[1] Frequency or responses compared to total number of subjects who responded (N).

32% of the families (Table II) stated that at least one of the respondents experienced at least one of the three major distress indicators (Panic attacks, serious withdrawal, or suicide attempts), with panic attacks being the most prevalent. There were only five cases, in which all three were experienced in the same family or individual respondent.

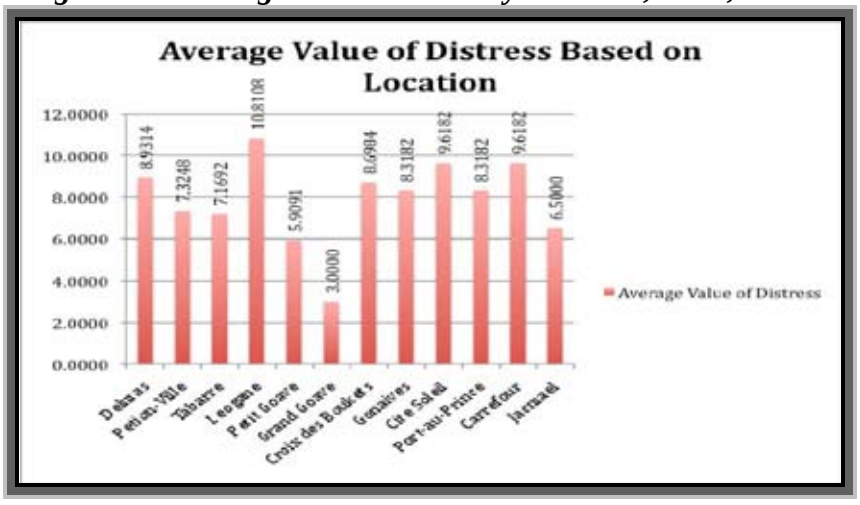
Table II. Prevalence of Major Distress Indicators *(N=693)*

Major Indicator of Distress	No. of families Experiencing indicator	Percentage of the Population (N=693)
Panic Attacks	170.00	24.53%
Suicide Attempts	61.00	8.80%
Withdrawal II	27.00	3.90%
At least one major indicator of Distress	222.00	32.03%
At least two major indicators of Distress	31.00	4.47%
All three Major Distress Indicators	**5**	**0.72%**

Distress and Location:

The questionnaire was administered at a hundred displaced settlements. These have been clustered together based on their location, by town or commune. Sixteen (16) different macro-locations were analyzed. The average composite of distress ranges amongst sites. The highest distress level scores were in Leogane (10.8), Cit e Soliel (9.6), Delmas (8.9) Croix des Boukets (8.69), Gonaives same as Port au Prince (8.31) and the lowest in Grand Goave (3.0), but the last is in fact an individual score. Difference in location is not significantly correlated with levels of distress.

Figure III: Average Distress Level by Location, Haiti, *N=635*



Even though there is no significant correlation between the geographic locations and the distress composite of the interviewees.

Distress and Social Indicators:

Social indicators were housing, security, scholarization, social life, food and water and sanitation. The table below illustrates the number of respondents for each item of the social indicators Table III.

Table III: Responses to Social Indicators by Frequency and Distress Score

HOUSING (1)	
	Number
House (property)	40
House (rent)	38
House (host family)	12
Shelter	64
Tent (camp)	260
Tent (host family)	8
Tent (neighborhood)	6
Random Setting/Other	181
	609
SECURITY (2)	
	N
Poor Security	249
Moderate Security	189
Average Security	106
	544
SCHOLARIZATION (3)	
	N
No	141
Yes	268
	409
SOCIAL LIFE (4)	
	N
Low Social Life	197
Good Social Life	261
Very Good Social Life	157
	615
FOOD (5)	
	N
Less than one proper meal per day	259
One proper meal per day	216
More than 1 proper meal per day	135
	610
WATER AND SANITATION (6)	
	N
Below Average	231
Above Average Cleanliness	259
Total	490

The general level of distress is significantly correlated with food ($p=0.039<0.05$) and more importantly security ($p=0.0001<0.01$). The higher the perceived security is, the lower the families score in their overall distress. The same is true for food. The more meals the families consume, the lower their levels of distress. However, the other indicators (housing, scholarization, social life, water and sanitation) did not show a statistically significant correlation with distress.

Table IV: Correlations between Social Indicators and Distress Levels

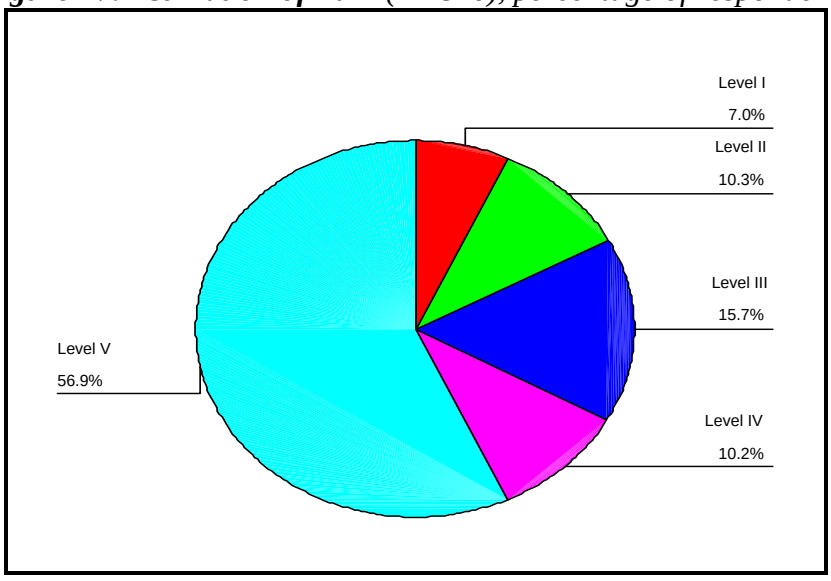
Well-Being (N)	Correlation	Significantly Correlated
Housing (N=647)	Negatively	No
Security (N=571)	Negatively	Yes, <0.01
Scholarization (N=433)	Negatively	No
Social Life (N=654)	Positively	No
Food (N=645)	Negatively	Yes, <0.05
Water and Sanitation (N=521)	Negatively	No

B) Quantitative Derivates of Qualitative Interviews with Families

Estimation of pain

In a scale from 1 to 5, being 1 the minimum and 5 the maximum, 60% of those interviewed stated they had a pain level of V, 10% stated they had a level of pain of IV, 15% stated they had a level of pain of III. A little over 10% of those who participated in the survey had a recorded pain level of II and III. The lowest level of pain, I, also had the fewest responses (7%) (Figure IV).

Figure IV. Estimation of Pain *(N=846), percentage of respondents*

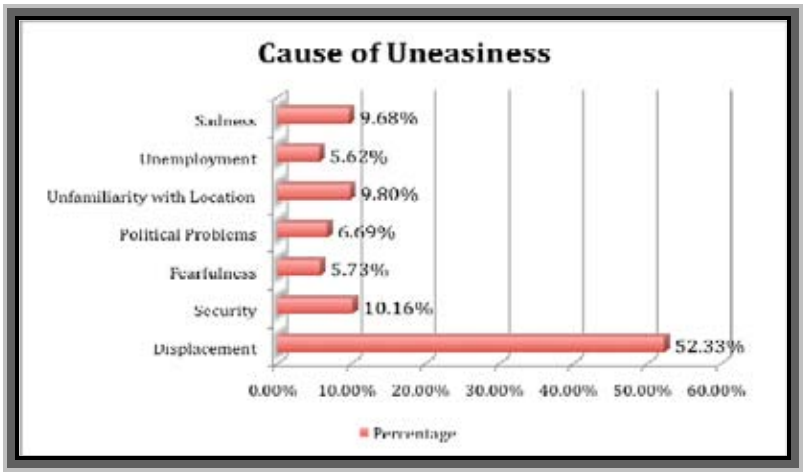


The self-reported levels of pain are significantly and positively correlated with the respondents' composite distress score ($p=0.000<0.01$).

Causes of uneasiness

The most frequent reported causes of uneasiness is displacement (52.33%) followed by security (10%), unfamiliarity with location (9.8%) and sadness (nearly 10%). Figure V

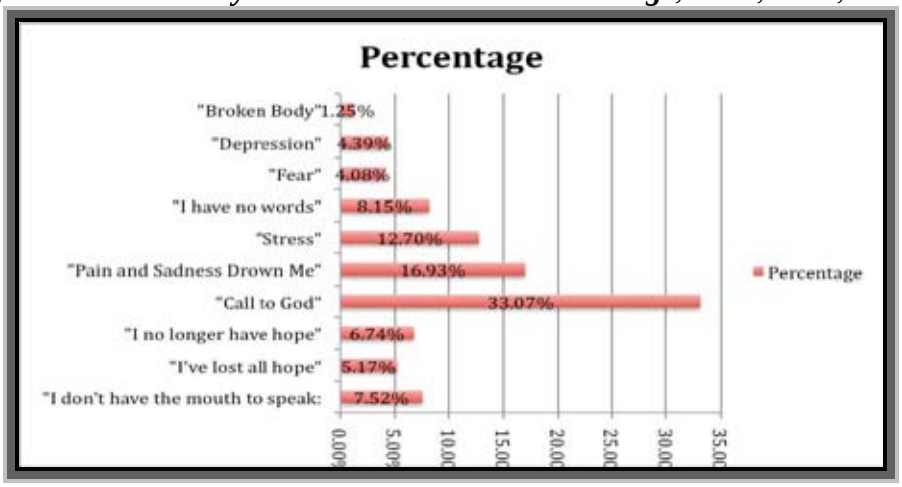
Figure V: Reported Causes of Uneasiness *(N=843)*



Definition of pain

When asked to identify with their own words the way the respondents' feel or how they can define their pain (commonly used idioms), the most commonly reported definitions describing pain are a need to *"Call to God," (33%)* , which is equivalent to a prayer to God. The second most popular response is a feeling of the *"pain and sadness drown[ing] them" (17%*). Terms like *"Depression"* and *"Fear"* are the least commonly used. Figure VI

Figure VI. Commonly used Word to Describe Feelings*, Haiti, 2010, N=638*

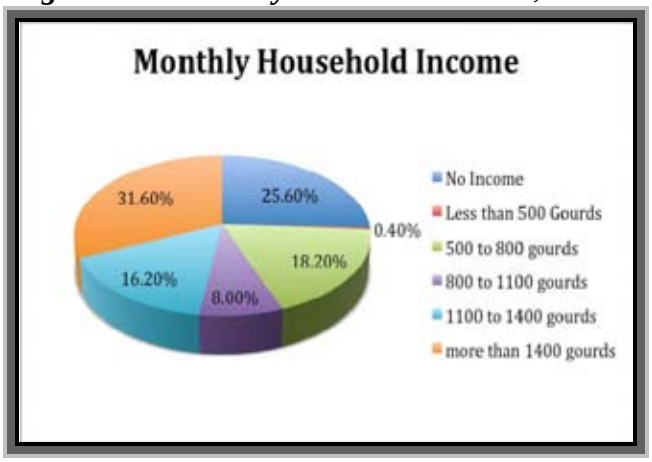


Magnitude of loss

53.28% of respondents lost someone during the earthquake. Among those, 62.5% have lost one family member, 24% lost two family members and the remainder lost three or more family members in the wake of the earthquake.
There is a statistically significant correlation between death in the family and level of distress ($p= 0.049< 0.05$). In families, who have experienced death of a family member, the level of distress is higher. However the magnitude of the loss is not significantly correlated with both levels of distress and the self reported levels of pain.

Income
Over a quarter of respondents reported that the family did not have any source of income. A third of respondents stated that the family made more than 1400 Haitian gourds a month.

***Figure VII: Monthly Houshold Income**, N=500*



However, no statistically significant correlation was found between the average distress and the income level.

Children going to school

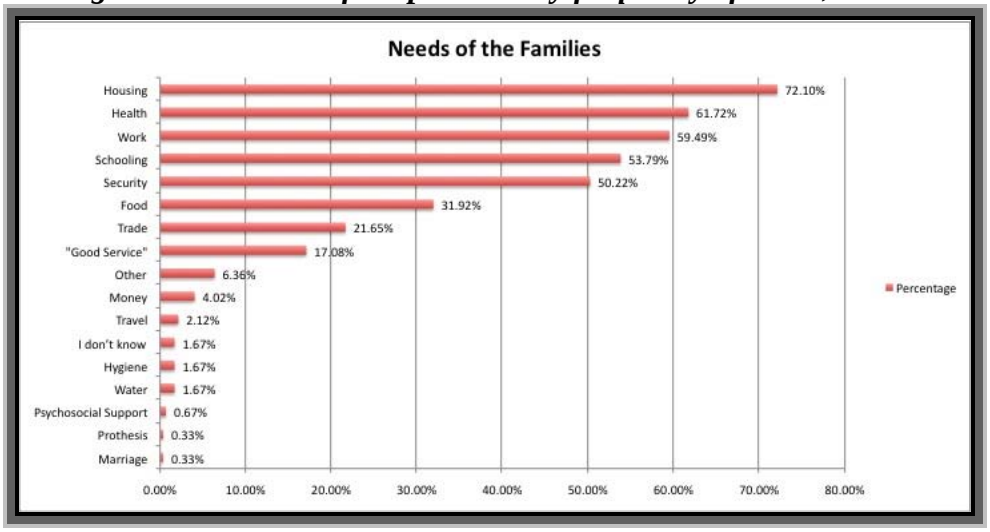
Less than half of the parents (48,7%) are able to send their children to school.

The inferential statistical analysis demonstrated that the fact that children go to school or can't do so is not significantly correlated with both the level of distress and the self-reported level of pain in the family.

Prioritization of needs

The study participants were asked to voice their three main needs. Over 70% of them listed housing as one of their top three wishes. It was followed by health (61%), work (59.4%) and then security (50.2%).

***Figure VIII: Needs of Respondents by frequency of Items**, N=950*



Access to Health and Social Services

54.3% of respondents stated that they had access to health and social services, while 45.7% indicated that they have no access. The infrential statistical analysis demonstrated that a satistically significant correlation exists between the location and the access to available health and social services. ($p= 0.000 < 0.05$) and between the type of house and the access to available health and social services $p = 0.000< 0.05$).

The results showed that type of housing that corresponds to poorer services are hanger, concrete houses and wood houses while those who lived in tents reported more availability of health and social services.

However, no statistically significant correlation exists between the access to health and social services and the level of distress.

Responses on coping

When asked how they cope with unpleasent feelings, over a third of respondents stated that they went to a friend for help. 22.1% called on God and 20.8% called on the community health center. While, when asked how do they respond to the family needs, close to 60% of those interviewed stated they struggled by themselves, 11.7% stated they would be willing to work in a low-paying job. None referred to NGO or IO services in this survey.

Figures IX& X

Figure IX Coping with unpleasant feelings

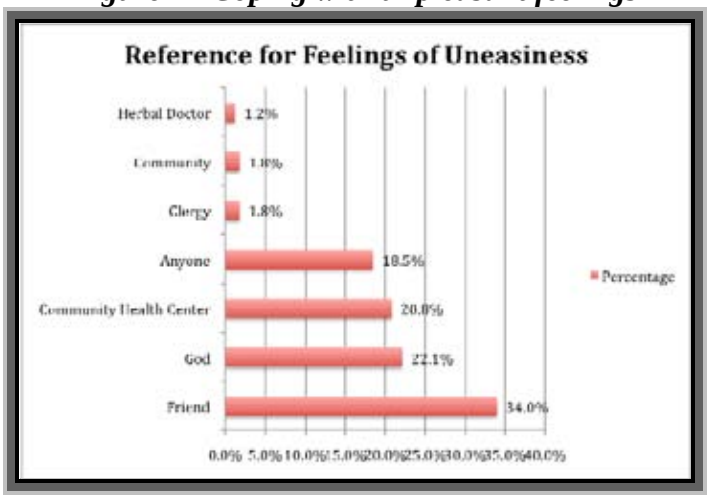
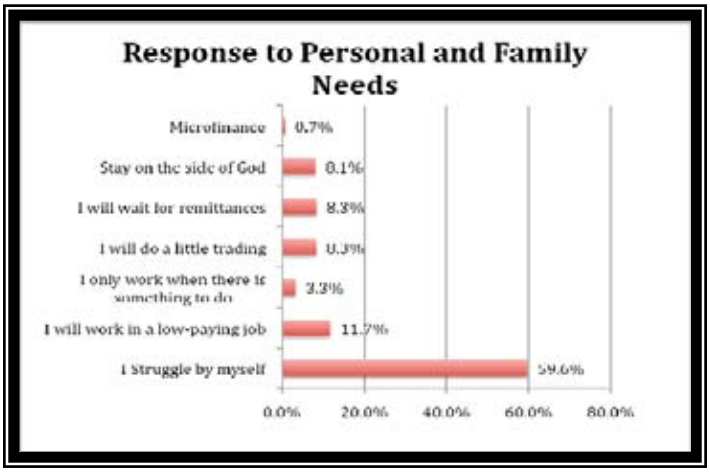


***Figure X: Response to Family Needs**, N=854*



C) **Qualitative Results: Interviews and Focus Groups**

Only issues important in relation to the quantitative component will be highlighted in this section.

The first set of questions aimed at looking at **housing and displacement** conditions of the family. Results indicated that the majority of the IDPs interviewed are living in sheet metal housing, wood houses and tents where they share their tents with other family members. Many of the IDPs interviewed expressed that they face the threat of eviction and restriction of movements. Families also expressed that there is a lack of safe spaces for children to play. IDP's described their displacement and their social circumstances as follows: *"I feel lonely, I am living in an area of the camp where I do not know anyone… my family got resettled in another camp"*. Many stated that they deal with these effects alone because they *"we were relocated to this camp and I do not have anyone to talk with."* Some participants in the group discussions described the following *"I do not want to visit anyone and share my difficulties and fears, people around were displaced as well and are even more stressed then me and have enough things to worry about…" "I am staying alone in my tent as I don't know and do not trust the people in the camp"* **. Security problems** are common in the camps. Some participants in the group discussions expressed their sense of insecurity as follows: *"the security here is more and more a problem, the prisoners escaped the prisons, they are here somewhere, maybe even in our camp…", "every day we hear stories of people we know who were raped, If I know that my security and the security for my children is insured I will not stress… I can not sleep because I am scarred of being raped…", "my children are supposed to go to school, I do not dare to send them, the streets are insecure, and what if another earthquake takes place…""Rape is a part of daily life for many in the camps because everyday we hear stories of people we know who were raped."* While they do not like their current residency and living in tents, they are also afraid of being kicked-out of their current residencies before they are able to find suitable housing. Many fear that they will be sent to new tent camps that are further away from any services and schooling for their children. They stated that they do not have the income to pay the transportation costs for travel to and from basic services.

The second sets of questions looked at how **economic, family, social and recreational life** has changed after the disaster. As for the family life, the head of the house was mostly the husband, wife or another family member or a friend. Some of the females from female-headed households expressed the sudden increase in the responsibilities they have to carry. They feel that after the loss or injury of their husbands due to the earthquake, they now have to assume the role as both "*mother and father*" for their children. While some households experienced the death of the primary income producer, other households had to deal with the fallout of an injured head of household. Many men feel emasculated because although they are physically present in the household, they are unable to work due to their disabilities (most commonly an amputation). They are left feeling that they are "*less than human*". The weight of responsibility often now rests with the women. The relationship of parents with children was also affected as many families expressed that they cannot control their children anymore, due to logistical considerations and the fact that children are becoming "*too free*" but also that parents "*became*

more impatient and aggressive with my family". Many families spoke about their hardship in sending their child to school and feel "*ashamed that they can't send their children to school"*, plus they think that lack of schooling is at the basis of the lack of structure in children's life, and the reason why some children now act like "*delinquents*." The children in exchange expressed the need to spend more time with their families and friends from school.
As for the **enlarged family,** according to the camps, respondents have praised the revival of Lakou system as one of their best protective achievements after the earthquake, or lamented the fact that the Lakou was dissolved or not considered in the organization of the camp.

Many respondents have lamented overcrowding, bringing to an unlimited and excessive need for socialization as a problem, and also a detriment to hygiene and health. Moreover people reported a more aggressive behavior in their neighbors and the population as a whole afzer the earthquake. Many individuals were *described as "easy to get upset;"* and they showed a disproportionate response to self-perceived grievances. "*There are certain things in the Haitian culture that are not done… now people don't mind doing impolite things."* There is a change in the sexual practices of many people since the earthquake. People were found to be more engaged in sexual activity. The interviewers stated that many of those they know say that they "*want to have sex all of the time."* The increase in teen pregnancy was widely reported as a by-effect of the increased sexual drive in all sectors of the population.

.People who have experienced death in their family have higher level of distress, and qualitative results suggest that lack of proper passage **rituals** may be one of the main causes of this distress, related with guilt, preoccupations as to possible possessions, and retaliation from the ones, who did not receive proper burial. Lack of burial ceremonies in the past make the families unwilling to practice new rituals, like funereal or weddings due to the guilt they feel for non being able to conduct proper burial to the ones deceased during the earthquake

The third set of questions trying to identify existing resilience mechanisms suggests that the families usually refer to clergy, friend, prayers, community support, traditional remedies or community health centers. Families turn to God because, to many of the respondents, "*only He can predict the future"*, "*He is the only one to trust because He is the only one who knows the future"*. Some "*fear the future look to God for guidance*". It is also noted that for some "*all of our hope is placed in God*."
Most reported coping mechanisms used by kids to respond to sadness or frustrations are going to bed, play music, talk with enlarged family members or read. Their favorite games are football, play station, play with dolls, play with legos, card games, video games, racing, dance.
When asked to identify the main actions that could be taken to improve the overall wellbeing, the families mainly referred to employment opportunities and economic development, basic services and cultural conservation and recreational activities.
The children required to make a list of the most three precious wishes reported schooling, future and housing. Children and adolescent are concerned about the likeability to continuing their education, and being able to fulfill their dreams (becoming a doctor, a nurse, a psychologists, serve God, lawyer, pediatrician…).

D) **Qualitative Results: Interviews with Stakeholders**

Definitions

The first set of questions aimed at assessing the general understanding of psychosocial concepts among the different layers of the Haitian society. Some local professionals working in the mental health and psychosocial field explained that the Haitian population does not have a clear understanding of psychosocial concepts; especially that some link psychosocial uneasiness with possession and the world of spirits. Among the professionals psychosocial pertains to 'combination of *psychological and social factors*". It's perceived by the beneficiaries as a series of actions that ensure security and reduce stress in the short term. On the long term psychosocial is instead, according to the professionals interviewed related to constructing roles, regaining self confidence, community involvement and offering space for expression of opinions.

Needs and recommended responses

According to the national stakeholders, academic, professional and religious the most urgent needs of the population are housing, security in the camps, food, health, education and rehabilitation. Several local stakeholders also highlighted the need for recreational spaces, intellectual creation and centers for creative expression and play-therapy. Entertainment is also considered important and the need for information on symptoms, stress and depression. They also highlighted the need for support to the population in the mourning processes.

According to stakeholders, the best responses should always reinforce the Lakou system in all the social, economic and cultural activities.

It was often recommended to establish psychosocial centers within the hospitals and health care centers in all ten departments in Haiti in the recovery and rehabilitation phases. Moreover, dedicated stand-alone psychosocial centers should, according to the stakeholders be established in all affected zones.

E) Mapping

A matrix of 'who is doing what' in psychosocial response in the county and a matrix of existing referral for people in need of specialized psychological and psychiatric services were developed. by the IASC working group on MHPSS and can be found on **www.psychosocialnetwork.net**.

The mapping revealed some significant gaps, mainly the overemphasis on psychological responses (e.g. individual and group counseling) and the insufficient focus on social and community-based responses. In addition to that, the mapping shows insufficient and centralized provision of specialized services.

The table below summarizes the Mental Health and Psychosocial interventions of local and international stakeholders that were reported to MHPSS working group:

Table V: Mental health and psychosocial services in the surveyed region

Individual psychological support	ACF, ADRA, AVSI, HI, IFRC, MSF-Belgium, MSF-ES, MSF-H, Red Cross-France, WV, Red Cross NorCan ERU, Psycho trauma center
Group psychological support/counseling	ACF, AVSI, HI, IOM, MSF-Belgium, MSF-ES, MSF-Holland, Red Cross France,Psycho trauma center
Psychotropic meds	IMC , Mars and Klein hospital, Beudet hospital
psychotherapy	ACF, MSF-Belgium
Other psychological/psychiatric support	IMC
Case management/social work	IMC, Msf-Belgium, MSF-ES, MSF-Holland, Terre des Hommes, Kore Timoun, Centre d'education populaire
Child Friendly Spaces	ADRA, ARC, AVSI, CISP, FHI, IDEJEN, IFRC, IMC, People in Need, Red Cross Norcan ERU, SAJ, Save, Terre des Hommes, Worl Vision , Group Intervention for Children (GIC), COCEQ,
Recreational activities	AVSI, GJARE, IDEJEN, IOM, Red Cross-France, SAJ , Tchaka Dance, Plas Timun, Kore Timoun,COCEQ
Including PS consideration in Protection activities	ADRA, IFRC, Terre des Hommes
Facilitating conditions for community mobilization	Red Cross NorCan ERU
Strenghtening community support and self-help	ADRA, ARC, AVSI, FHI, IDEJEN, IFRC, IOM, MSF-Holland, Red Cross-Holland, Red Cross France, Terre des Hommes
Advocacy	Terre des Hommes
Providing information to the community	ACF, AVSI, MSF-Belgium, MSF-Holland, Terre des Hommes, IOM
supporting teacher's psychosocial well-being and training	AVSI, MSF-Belgium, Terre des Hommes
Social considerations in nutrition, and WATSAN	ACF, ADRA, AVSI, People in Need, Saude em Portugues, Terre des Hommes
other social support	Terre des Hommes
General activities to support MHPSS	HI, IMC, People in Need, Red Cross-France, UNICEF, World Vision, IOM

Training and capacity building

With respect to trainings and capacity building, several organizations offered trainings in the psychosocial domain in the aftermath of the earthquake. These are summarized in the table below:

Table VI: Sector Agency Description Number of trainees

Sector	Agency	Description	Number of trainees
Psychosocial response in emergency	URAMEL IOM	Pyschotrauma and techniques of sensitizing Psychosocial Response to disasters & Art based intervention Psychosocial response to disaster and psychosocially aware provision of humanitarian assistance provided to camp managers and humanitarian workers active in the CCCM cluster lead by IOM	 229 560
Primary health care	ITECH	Health information system Psychosocial follow up of HIV	
Psychosocial response in humanitarian work	French Red Cross World vision IRC PRODEV CMBM Centre MD claude UNICEF ITECH Project KID	Basic psychological skills Interpersonal psychotherapy for groups Lifeskills training Basic counseling skills GBV and Referral training Psychosocial for teachers Stress Relief and Resiliency building Conflict Resolution Play Therapy Post Traumatic Stress The Power of Play	
Psychosocial response and vulnerable categories (specify)	MWA Start International	Understanding and treating traumatic stress in children , adolescents and refugees Artistic, de-traumatizing and therapeutic work with affected children and adolescents	
Specialized mental health	IMC IOM	Clinical Mental Health Trans-cultural and Transnational Mental Health Response Models Systemic and Family approach	 103 119

** The number of trainees is reported by the relevant organizations*

The mapping also revealed the following:

- Mental health is not mainstreamed into primary health care, even though 50 circa general practitioners educated in Cuba have received basic education in psychological health.

- Only one medical student is currently specializing in psychiatry in Haiti.

- Psychological services, a part from the above-mentioned staff, are offered only by private hospitals (mainly DASH) or practitioners, and by NGOs and faith based organizations in the form of counseling.

- It is estimated that 60 licensed psychologists operate in the country, most of them quite junior.

- The University of Haiti has 2 departments of Psychology, attached to the faculties of Human Sciences and Ethnology respectively. Both departments offer BA courses, and students can complete the studies with a thesis, obtaining a license. No MA or clinical doctorates are offered in the Country. BA graduates are around 80 per generation.

- The table below summarizes the academic courses offered by universities in Haiti:

Table VII: Academic Courses offered by Haitian Universities

Subject	University
Psychology	State University: Faculty of Ethnology and Faculty of Human sciences, ***(Undergraduate study: Bachelor level)***
Social Work	State University: Faculty of Human Sciences, ***(Undergraduate study: Bachelor level)***
Psychiatry	Faculty of medicine(State University), University Notre Dame and University Quisqueya ***(Specialization)***
Community Animation	Faculty of Ethnology and Faculty of Human Sciences, University of the states ***(Undergraduate study: Bachelor level)***
Mental Health nurse	National School of Nursing (ENIP), University Quisqueya, Notre Dame University, ***(Undergraduate study: Bachelor level)***
Social Theater/Applied Theater	National School of Arts (ENARTS), ***(Undergraduate study: Bachelor level)***
Education	Ecole Normale Supérieure (ENS). Quisqueya University, ***(Undergraduate study: Bachelor level)***

IV. DISCUSSION AND RECOMMENDATIONS

The qualitative and quantitative assessment enabled a holistic understanding of the experiences of the study participants.. In natural disasters, indeed usually the causal agent is seen as beyond human control and without evil intent. The meaning the survivor and the surrounding community assign to the disaster, the survivor's inherent personality and resilience, and the survivor's world view and spiritual beliefs contribute to how that person perceives, copes with, and recovers from the disaster in its own family, group and societal context.

When asked to categorize their level of pain in a scale from 1 to 5, being 1 the minimum and 5 the maximum, 70% of those Haitian interviewed stated their pain can be categorized above 4.

The average score of distress among the interviewed families is of 8.32/35, with headaches, sleeping problems, anxiety and fatigue being reported as the four most common indicators in more than half of the families interviewed. Generally, these results, which refer to family and not individual scores, are indicative of a state of uneasiness, but can be still considered as normal emotional reactions to the abnormality of the events, the slow pace of the humanitarian response, and the level of pain the family are undergoing. By contrary, 30.2% of families reported that one or more members of the household have suffered panic attacks (24,53%), and withdrawal making people unable to function (3,6%) or have attempted suicide (8.8%) in the last three months. Those are considered by WHO conditions calling for immediate referral. The clinical definition of panic attacks may be unknown to most of the participants, may have not been clarified enough in the roll out of the trainings for interviewers; and therefore may have been trivially attributed to general states of unresolved fear. However attempted suicides registered in the 8.8% of the families testify the necessity to respond to the psychosocial uneasiness of the population, acting on the interconnected psychological, social and cultural anthropological sources of distress.

Of all the possible causes of distress analyzed in this study, three only are statistically significantly correlated: perceived levels of personal safety-security, death of significant others, and access to food. Moreover, displacement is identified by more than 50% of the respondents as the main cause of concern and pain.

As for **personal safety-security**, people identify lack of the rule of law, presence of gangs and political unrest, lack of police patrolling and or corrupted police officers, overcrowding in the camps and gender sexually based violence as the main sources of concern. The possible reiteration of natural disasters, preventing many to leave the camps is another source of stress.

Conditions of life in the camps are also perceived as very physically insecure, because unhealthy, due to a combination of overcrowding and dirt, and threatening due a combination of overcrowding and loneliness-estranation. It has to be noted that this report was closed before the outbreak of cholera pandemic, and therefore the feeling of health un-safety may be even stronger today.

Major cause of uneasiness is identified by more than half of those who responded in displacement due to the earthquake. Nine months after the earthquake, over 2/3 of those who have been displaced live still in tent of some kind. The second largest type of housing is the sheet metal house. These types of homes are temporary by construction and have hardly met the needs to deal with the environmental landscape of Haiti's seasonal hurricanes. Moreover, displacement is associated with de-rooting and lack of social life, since a large part of the respondents identify unfamiliarity with the new place and neighbours as the major cause of uneasiness.

The shock of current displacement meets with the fear of future displacement. Individuals do not want to be moved to another location because they do not know where they will be sent. They are fearful that the new locations will be far away from the many services they rely upon. There are newer camps being constructed, but in remote locations, that most people do not want to relocate because they cannot afford the transportation cost. Many displaced individuals had to also remove their children from school because they could not afford the transportation to and from the IDP camp.

While the explanation of insecurity all refer to life in camps, and security determines distress, and while the main source of pain is identified in the tuff conditions related with the displacement in the camps, type of housing (including camps) is not significantly correlated with levels of distress. However, this is likely to be a result of a statistical bias, since an overwhelming majority of respondents happened to live in camps versus other kinds of accommodation, making the difference between accommodations experimentally irrelevant.

- As a consequence, based on the research results, in order to resolve the level of distress of people actions will have to be urgently initiated aiming at a) reduce overcrowding in camps b) enhance protective elements in the camps c) prevent gender based violence. Based on the response of the participants, it seems that a reorganization of the camps across lakou lines, both in terms of the population allocated in them and the physical organization of the spaces in courtyards, could be a fast solution to the immediate problems of overcrowding, safety, protection towards GBV and other possible violent behaviors in the camps. Moreover Participants are requesting well-lit, open-space, safe areas places for socializing. However, on the mid term, a focus needs to be given to d) durable housing solutions, that won't undermine the economic and social life of residents due to distance from vital economic and cultural centers e) restoration of a sense of legality and rule of law.

<u>Access to Food</u>

Access to food is significantly correlated with levels of distress. Access to food is also significantly determined by location. Therefore, it is essential that psychosocial and nutrition actors act in a timely fashion to respond to the urgent nutrition needs of the populations of those locations that can be identified through a break-down of the results of this study. No psychosocial wellness can exists where essential and basic needs are not met, and results of this study are just reinforcing the obvious in this respect.

Death of significant others

53% of respondents lost a close family member during the earthquake and a statistically significant correlation exists between death in the family and level of distress. However life losses were not reported by the participants among the causes of concern, pain, and uneasiness at any point of the interviews or focus groups. Moreover, magnitude of the loss, or plainly put the number of losses in the family is not correlated with levels of distress or pain. By contrary, people referred a lot in the qualitative responses to the uneasiness in relation to the impossibilty to conduct proper funereals for the ones, who died during the earthquake. An interpretation of these conflicting data could be that death of significant others may not be a very painful experience within the Haitian cosmologic explantory and value system, based on a lively relations between the world of the livings and the one of the deads, and dedicated rituals. However, the impossibility to conduct proper funereals for the deceseaded still provokes distress, and differentiate significantly the ones, who lost family members from the ones who didn't.

Deaths were sudden and unexpected, allowing survivors no time to say goodbye or to prepare for the loss. Far from the popular perceptions of magic and sorcery, voodoo's rituals and practices are viewed as ways to honor and remain connected to one's ancestors. The mourning should be visible (cloth and rituals) and the religious rites in their honor prevent their souls from becoming "abandoned spirits" and consequently malefic spirits in particular towards their close family members. On the contrary, if the soul of a lost family member is "well served" it can help and protect the living against dangers. (Legrand Bijoux ,1999). As a result, the inability to bury loved ones properly in family plots is likely to be extraordinarily upsetting for adherents[i].
Voodoo burial rituals include practices intended to make sure the dead do not come back to life as zombies, so in addition to grief over the loss and guilt and distress over the disrespectful disposal of their loved ones' remains that anyone would feel, Haitian survivors may also be experiencing the fear that spirits of the earthquake victims buried in mass graves will rise from the dead. Understanding and respecting this fear is essential for helpers working with bereaved Haitians, whether they experienced the earthquake themselves or are coping from afar with the loss of a loved one. General data suggest that well performed commemorations, which value the disappeared and allow their relatives to play a positive role, have positive effects on mental and physical well-being, in most communities. This seems to be particularly the case in Haiti. The preparation, in collaboration between religious and traditional religious leaders of a country dedicated ceremony, that could serve as definitive closure of the issue of burial, accepted by the families and validated traditionally, religiously and on a community level, is a possible response to the sense of distress due to death of significant others and the inability to perform proper burial rituals at the time of death.

Services and Coping mechanisms

Even if access to services is not significantly correlated with distress, it is an issue of concern. The study stated that over 50% of those interviewed stated they had access to medical and social services. Thus, close to half of beneficiaries of humanitarian services are often not aware and unable to navigate what is available. Without awareness of all of the services available to the individual, the psychosocial wellness of the family can be compromised. Majority of families interviewed were also not fully aware of the psychosocial services that were available to them and whether there are services free of charge. Therefore urgent actions to harmonize the

available services, communicate their availability in a transparent fashion, outreach to the most needy ones, and counsel them in prioritizing needs becomes essential. Access to services is significantly correlated with locations, so a break-down of the results of this study can help prioritizing areas of major concern in services access.

Other issues of concern:

A part from the most significant results related with current distress, the study highlighted several challenges in interpersonal, parental, family, community and societal relations that may affect the wellbeing and functioning of the Haitian affected populations on the long run. The change in family dynamics is not just limited to the changing relations between the men and women in a household. It also refers to the changing relationship between parents and their children. Most parents no longer feel that they have any control over their children and that the children are becoming "too free", or because they are themselves unable to control their emotions. Children, by contrary, are unsatisfied by the level of sharing with their parents, lament a scarce socialization and suffer from lack of schooling, especially because they fear this may affect their future expectations. Many women are now the heads of households, and do not feel that they are able to provide the security that their families need. On a more general level, many respondents report an over-sexualization of the relations between genders, and an increase in community and interpersonal aggressiveness, a strong lack of trust and paranoia in relation to the others, and the capacity of the state to establish justice and rule of law in case one becomes a victim of a crime or injustice. The last reports are particularly worrying in a Country that have witnessed civil conflicts and is in a delicate socioeconomic moment, and where the coefficient of wealth inequalities is one of the highest in the world, fuelling possible violent outbreaks. The magnitude and long term possible effects of these reported concerns call for comprehensive psychosocial programs and for the creation of the capacity of the country to respond to individual, familial, group emotional and relational problems and conflicts in community based fashion, in a timely fashion but looking at long-term needs and outcomes.

Summary of Recommendations

a) To enhance access to food in areas where distribution is not upon standards since this is a significant source of distress.

b) To enhance protective elements in the camps and prevent gender based violence. A reorganization of the camps across lakou lines, both in terms of the population allocated in them and the physical organization of the spaces in courtyards, could be a fast solution to the immediate problems of overcrowding, safety, protection towards GBV and other possible violent behaviors in the camps.

c) To provide safe, well lit spaces for socialization in the camps and structured activities.

c) To provide durable housing solutions, that won't undermine the economic and social life of residents due to distance from vital economic and cultural centers

d) To restore of a sense of legality and rule of law, possibly in a participatory community- based fashion.

e) To device and implement, in collaboration between communities, religious and traditional religious leaders of a Country dedicated ritual funerary ceremony, that could serve as definitive closure of the issue of proper burial of corpses.

f) To harmonize the available services and communicate their availability in a transparent fashion. It is recommended to establish or potentiate outreach-information teams, working in close collaboration with cluster and governmental systems, and with camp authorities.

g) To establish a newsletter for camp distribution and radio ads on available psychosocial services.

h) To establish a website of the humanitarian agencies' resources.

i) To respond to the long term outcomes of the current situation, building in service the capacity of the country to respond, through the establishment of an in service master program in psychosocial responses at the individual, family and community level, and the creation of a national expert team.

A part from the results of the study research, stakeholders formulated as series of recommendations that are summarized here below

- ***Culturally sensitive programs***: Haitians have strong attachment to cultural systems and values. MHPSS programmes should be community-based, family-focused and culturally-sensitive. The community should draw on their own resources to guide and lead MHPSS programming for sustainability
- ***Avoid duplication of services***: Organizations are concentrating on the same activities like child friendly spaces and group responses, and in the area of Port Au Prince. Thus brings to duplication as well as produces several gaps, both geographical and in the services provided.
- ***Mental health Structure***: Many organizations are concentrating on psychosocial support and neglecting specialized mental health services. There is need to develop specialist psychiatric services for referral, and encompass traditional practices and trans-cultural models in the services.
- ***Integration of mental health in health***: Mental health should be integrated with other medical outreach services. People living in areas hardly hit by the earthquake are suffering from all kinds of lingering maladies such as lost limbs, broken legs, eye and ear injuries as well as head injuries thus a need for integration to meet these health needs exists.
- ***Integration of livelihood within psychosocial programs***: Integration of the psychosocial and livelihood programmes is advocated. MHPSS programmes are successful when invested within rebuilding local economies. On the other hand, MHPSS programmes provide a multiplier effect on livelihood programmes.
- ***Child Protection****:* child protection is to be included in any psychosocial structure due to vulnerability of children and their situation in the country even before the earthquake.

- ***Maintain mobile teams***: Maintaining mobile clinics that address health issues, others addressing mental health issues, and psychosocial mobile teams due to lack of physical structures mainly in suburb and faraway communes.
- ***Introducing psychosocial support modules*** in all primary and secondary schools, in addition to specialized courses (on psychosocial response in emergency settings) at universities to enhance local capacities in responding to emergencies.
- ***Launching awareness campaigns*** regarding the importance of mental health and psychosocial support/ wellbeing.

Annexes

Annex I: List of Interviewees for the psychosocial needs assessment Haiti

*International stakeholders

ACF (Action Contre La Faim), Elisabetta Dozio , Psychosocial Project Coordinator

CONCERN, Verane Braissand, psychosocial coordinator

French Red Cross, Antoine Terrien, psychosocial delegate

Food for Hunger, Wendy Bovard, Director of protection and psychosocial program

IMC (International Medical Corps), Kettie Gednard, psychologist

IOM(International Organisation For migartion), Marie Adele Salem, psychologist

MdM Canada, Guylaine Dion, psychologist

MdM Spain, Irene Hernandez, psychologist

Plan Intrenational, Julie Grier, Sr Psychosocial program manager

Salvation Army, Brian Swarts and Vicki Poff, Technical advisor

Save the Children, Sandra Sector, Staff support psychologist

UNICEF, Emmanuel Streel, MHPSS coordinator

US EMDR

WHO, Zohra Baakouk, Mental health consultant

Worldvision, ***Alice Male, MHPSS technical advisor***

*National stakeholders

Assembly of Jehovah Witness

Centre D'Education Populaire, *Vanel Lominy*

Center Gaou Ginou-Kosanba, *Viviane Nicolas*

Center Marie Denise Claude, *Marie Denise Claude*
Center of Trauma, Roseline Benjamin, Pyschologist

Centre Psychiatrique Mars and Klien, *Dr. Louis Marc Jean Girard*

Coalition de la Jeunesse Haitienne pour l'integration (COJHIT), *Alain Alfred*

Comite de Gestion (Camp tapis/Athletique II), *Elisma Etzer*

Comite De la Cour des Enfants de Quettsar (COCEQ), *Nedgie Phanord*

Comite Victime Seisme

Direction de la Protection Civile, *Marie Lita Descollines*

Faculty of Ethnology-State University of Haiti, *Dr. Serge Haycinthe*

Faculty of Human Sciences- University of Haiti, *Dr. Carmen Flambert Chery*

Faculty of Human Sciences , *Dr. Lenz Jean Francois*

Gheskio Center, *Dr. Margareth Collin Paultre*

Group Intervention for Children (GIC), *Yolmar Ronald*

Haiti Tchaka dance(HTD), *Bruma Daphnis and Jerome Jacques*

Holistic Health Center *,Justimee Lucienne*

International Training and Education Center- I Tech, *Jean Marxime Chery*

KF Foundation (Kore Timoun), *Junie Bertrand*

Dr. Marjory Mathieu, *Clinical psychologist*

Ministry of Culture *, Mr. Jean Yves Marie Blot*

Missionary of Sacre Coeur, *Pere Antoine Edmond*

Plas timun, *Philippe Dodard, Artist*

Partners in Health, *Pere Eddy Estache*

Dr. Phillipe Jean Justine

SAJ Association, *Joseph Innocent*

Traditional Healer: Mambo Marie Lourde Jeanne Celikaro

Union des Jeunes pour le Développent Humain Réel et Durable (UJDHRD), *Jean Charles Mervil*

Annex II: Questionnaire for international and national stakeholders

Date
Interviewee
Organization
Role/Position within the Organization

BACKGROUND
Mental health and psychosocial needs: documents and papers 1. Can you provide me with any information you have on existing mental health and psychosocial needs of the displaced community in the country, including documents and papers? **Mental health and psychosocial needs: provisions** 2. Can you provide me with any information you have on existing mental health and psychosocial provisions for the displaced community in the country, including further contacts? **Projects devoted to psychosocial activities** 3. Can you provide me with any information about the project your organization is running in the domain of psychosocial activities, including project documents and reports? **Projects including psychosocial response (also other organization's ones)** 4. Can you provide me with any information regarding projects your organization or other organizations targeting the displaced community in the country, with particular regard to psychosocial response? **Number of beneficiaries** 5. Can you give me an estimate of the number of your beneficiaries within the displaced community?
NEEDS ASSESMENT

Psychosocial issues to be addressed

6. What do you think are the main and most urgent psychosocial issues to be addressed for the displaced community?

Psychosocial support system to be built

7. From a long-term perspective, what do you think are the main structural psychosocial support systems to be established?

Longstanding and new needs

8. Which of these needs are longstanding and which are the result of the new social, political and security situations?

9. What are the subjects-areas to be addressed?

Special needs

10. Are there any special psychosocial needs concerning the displaced community?

11. Can you list them please?

NEEDS RESPONSE

How to address psychosocial needs

12. Do you or your organization have any idea, plan or strategy for addressing psychosocial needs of the displaced community in the country?

Resources

13. What resources would be needed to address those needs?

IOM's role

14. What could be IOM's technical role in supporting these projects/strategies?

15. Would you be interested in collaborating with IOM regarding psychosocial issues in the future? If yes, with which role/function?

Cooperation with IOM and shared info

16. If IOM was to conduct a study on the psychosocial needs of the displaced community, would you be interested in collaborating with the understanding that IOM will share relevant documents and findings with your organization?

Annex III: The Names of the Study Participants' Camps

ACBL
Anba bannan
APPAD
Athletique II
Automeka
AVDJ
Barbancourt
Bas fontaine
Baz Pinya
Benoit
Bolos
Boulos
But Boyer
Caiman
Camau
Campeche
Caradeux
Carrefour
CFS Fort Carriere
Champ de Mars
Christ Roi
Cineas
Cite La Joie
Constant Nicolas
Cx des Missions
Delmas 75
Delmas 89
Diobel I&II
Duval 33
Ecole N Louverture
Eglise de Dye
Enfrasa
Espas Zanmi Ti Moun
Fakilte Syen zimen
Fami d'Accueil
Fantamara 27
Garnier
Gonaives
Grand Goave
Haka
IDP/CampUNAH
IKA
Impasse Israel
Impasse regale
Juvena
Kleb Pinya
Korail
Kwa de Bouket
Lindor
Meyes 5
Nan Bannan
Nan Do Estephia
Neret I
Neret II
Neret IV
No response
Notre Dame de Lourdes
OJDCP
OLD Aiport
Pak Lebon
Pak Semine
Pako
Palais de l'Art
Parc Olympia
Parc Saint Marie
Petion Vil Club
Petite Savane
Pina
Plas des Atis
Plas Dessaline
Plas Penitansye
Plas Petion
Plas sen Pye
Poupelard
Privantorium S Antoine
Raquette
RCDPC
Ri Boukan
Rue camo
Salesienne
Sans Fil
Sant Sp Kfou
Sent Teres
Siloe
Siloye
SM1
SM2
Solino
Stephia
Sylvio Cator
Tabarre ISA
Terain Pe
Terain Pe Solino
Teren 4
Teren Acra
Teren Blanche
Teren Golf
Ti Savan
Trazelie
TSF
Vale de Boudon
Venus

Annex IV: Study Questionnaire

A. Questionnaire for Households

Department
Neighborhood/site
Commune
Place (village/ town)
Name of the camp
Name of interviewee
Organization
Interviewer status
Date:
Time start:
Time finish:

LIVING CONDITIONS
1. What kind of housing do you have?
2. Are you sharing your housing with others?
3. Does the family face a threat of eviction at any moment?
4. Does the family have any restriction on the freedom of movement in your current residence?
5. How much do you pay for the rent per month?
6. How many rooms there are in the dwelling?
7. How many of these are bedrooms?(only if applicable)
8. Do you think children have a safe place to play?
HOUSEHOLD LIST
9. Age and gender
10. The date of arrival to the current place of habitation
11. What is the respondent's relationship with the head of the house
12. Have you lost any member of your family due to the earthquake?
13. Which educational level have you accomplished?

14. What kind of economic activity did you have in your country/town/village (before displacement)?

15. Do you work more or less than 15 days per month?

16. How many members of your family have economic activity?

17. What is your monthly income? 500---800 gds 800---1100gds 1100---1400 gds more than 1400gds

18. What is your employment now? Is it regular or occasional?

PSYCHOSOCIAL CONDITIONS

19. Is there a word you traditionally use to define a period of temporary distress or uneasiness?

20. Is this feeling widespread in your community? *The interviewer will try to bring the conversation on family and personal issues. The interviewer can refer to his own experience.*

21. Do you have a temporary feeling of this kind?

22. Can you give me an estimation of this pain?
(The interviewer asked this using his 2 hands as measurement. Little space between hands means little pain and big space between hands means too much pain. In a total of 5 hands measures (from 0 to 5)

23. What are the causes of uneasiness? *In case the answer takes too much time, the interviewer might suggest migration, the security and political situation in the country.*

24. Is it possible for you to keep respecting practices rites such as marriages and funerals?

25. Do you bring up issues and memories on your lost houses and relatives? with whom?

SOCIAL SKILLS

26. Did the emergency displacement and/or the security situation change the roles in your family?

27. Did you manage to make friends in this camp/place? (Are they friends that you had before i.e. they fled with you; are they from your own community already living here; are they from the hosting community)?

28. Do all your children currently go to school? If not, why?

29. do they have extra-curricular activities?

AVAILABLE SERVICES

30. Can you provide me with information on the existing services to respond to your personal or family uneasiness? (This can include medical services, legal counselling, traditional healing and informal community help).

31. Are there more informal ways of coping with the situation? If yes, explain.

32. Whom do you usually refer to when you have a feeling of uneasiness?

33. Do you have access to available health and social services?

NEEDS ASSESMENT

34. Apart from material needs, what do you think are the main issues provoking personal concerns
that needs to be urgently addressed within your community? Concerns refer mostly to psychosocial
issues.

35. Can you prioritize these needs by order of importance?

36. Do any of these issues provoke suffering to you and your family as well? How? (Conversational
fashion).

37. Do you think your children are getting the same opportunities for education as other children in
this camp/place?

38. Can you state three wishes that are most precious for you?

response

39.how do you respond to your personal and family needs?

40. In your opinion, which are the actions that could be taken in order to improve the overall wellbeing
of your community? Which one can respond best to you and your family personal suffering?

41. what can you do to help with designing the activities? Can you suggest anything you will personally find useful?

42. what can your community do?

FOCUS ON CHILDREN

43. The number of children in the household.

44. Gender and age

45. How do you feel about your new place?

46. Who takes care of you at home?

47. Do you go to school? Do you enjoy it?(only if applicable)

48. Do you have friends at school? If not, why?

49. With whom do you usually play?

50. What is your favorite game?

51. Do you have any recreational activities in your local community? What kind of activities?

52. Who is the person you like most to spend your time with?

53. How often do you see him/her and spend time with him/her? 54. How do you feel during the day? ☹ 😐 ☺ 55. What do you usually do when you feel like this? 56. can you give me 3 words that describe the place where you are living? 57. can you state three wishes that are most precious to you? * It must be noted that questions concerning *ethnical affiliation*, *religious orientation* and issues which may be sensitive for the interviewee are not be directly asked by the interviewer but acknowledged through observation.

B. Scheme for the family well being:

In order to evaluate the psychological status of the families, IOM developed the following table that corresponds to five social indicators: Housing, Security,Alphabetization/ Scholarisation ,Social life, Food, Water and Sanitation:

Housing	a- House (property) b- House (rent) c- House (host family) d- Shelter e- Tent (camp) f- Tent (host family) g- Tent (neighborhood) h- Random setting/oher
Security *up to 2 indicators: mid- security* *3 to 5 indicators: low security* *Over 5 indicators : very bad security*	a- Fear of disappearance of children b- Fear of rape c- Fear of being robbed d- Fear of being relocated e- Fear of ghosts f- Fear of dark g- Absence of police h- Fear of being attacked/ aggressed

	i- Fear of gangs j- Fear of animals k- Fear of houses in concrete l- Fear of rainy season/cyclones
Alphabetization (1) / Scholorization (2)	1 – (a) yes (b) no 2- (a) yes (b) no
Social life *Up to 2 indicators: low social life* *3 to 5 indicators: good social life* *Over 5 indicators: very good social life*	a- One contact with original community once per week b- Family unity c- One contact with family once per week d- Going to church / peristil once per week e- One member of family volunteering f- One member of family going out to work g- Socializing once per week (peer group, friends,dancing clubs,etc)
Food	a- Less than one proper meal per day b- One proper meal per day c- More than 1 proper meal per day
Water and sanitation	a- Acces to potable water b- Acces to clean latrines c- Acces to sinks and showers d- Cleaning of trash e- Acces to hygine kits/cleaning products

This scheme allows for room for manoeuvre in terms of both needs identification and type of psychosocial response. Indeed, due to the way it is designed, the scheme allows the assessor:
* To investigate the psychosocial well-being of the family according to a thematic area (Housing, Security, Alphabetization/ Scholarization, Social Life, Food, water and sanitation).

The scheme relies heavily on the interpretation of the assessor. In this respect, if time allows, fixed indicators for each of the measure can be established, possibly in coordination with the IOM Central Unit for Mental Health, Psychosocial Response and Cultural/Medical Integration.

C. **Distress list indicators**

The list of distress indicators includes 28 items. The assessors are requested not to make specific questions regarding the health status of interviewees. Whenever during the interview the Interviewees would mention a distress indicator present in the list, either self reporting it, or attributing it to another member of the family, the interviewer will mark it.

The aim of the exercise is indeed not to identify individual pathologies, but to evaluate the recurrence of certain issues in a community, consistently with the non-medical aim of the assessment.
This exercise can be applied with both individuals and families as a whole.

When a high number of distress indicators (more than 5) is present within the same household or in the same individual, either self reported or attributed by other members of the family, the individual/family may be referred to a mental health professional.

To not extent the interviewer should assess symptoms but just note spontaneous self-reports.

- Sleeping problems
- Weight problems/ Appetite problems
- Tiredness
- Headache
- Tachycardia
- Memory loss
- Impotence/loss of menstruation
- Aggressiveness/ rage
- Violence
- Learning problems/lack of concentration
- Anxiety
- Nightmares
- Somatic complaints
- Hyperactivity
- Culpability
- Fears
- Hyper vigilance
- Panic attacks
- Burst of tears
- Suicide attempts
- Substance abuse (alcohol, cigarettes, others...)
- Bed wetting
- Withdrawal 1[2]
- Withdrawal 2[3]
- Fits, compulsion, seizures
- Detachment
- Isolation
- Flashback

[2] During the last 2 weeks, was s/he so distressed/ disturbed/ upset that s/he was **completely inactive or almost completely inactive, because** of any such feelings?

[3] During the last 2 weeks, for how many days was s/he so distressed/ disturbed/ upset that s/he was **unable to carry out essential activities** for daily living, **because** of any such feelings

ANNEX V:

Correlations between Subcategories:

Correlations

		Composite of Distress	Security (2)	Food (5)	Sex of the Participant	Geographic Location
Composite of Distress	Pearson Correlation	1	-.161**	-.084*	-.027	.074
	Sig. (2-tailed)	.	.000	.039	.503	.063
	N	693	544	610	611	635
Security (2)	Pearson Correlation	-.161**	1	.029	.023	-.042
	Sig. (2-tailed)	.000	.	.511	.609	.333
	N	544	571	529	501	530
Food (5)	Pearson Correlation	-.084*	.029	1	-.045	.067
	Sig. (2-tailed)	.039	.511	.	.283	.102
	N	610	529	645	572	592
Sex of the Participant	Pearson Correlation	-.027	.023	-.045	1	-.039
	Sig. (2-tailed)	.503	.609	.283	.	.291
	N	611	501	572	843	740
Geographic Location	Pearson Correlation	.074	-.042	.067	-.039	1
	Sig. (2-tailed)	.063	.333	.102	.291	.
	N	635	530	592	740	832

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Correlations

		Composite of Distress	Housing (1)	Security (2)	Alphabetization/Scholorization (3)	Social Life (4)	Food (5)	Water and Sanitation (6)
Composite of Distress	Pearson Correlation	1	-.007	-.161**	-.037	.042	-.084*	-.014
	Sig. (2-tailed)	.	.856	.000	.456	.295	.039	.756
	N	693	609	544	409	615	610	490
Housing (1)	Pearson Correlation	-.007	1	-.009	-.011	.071	.041	-.013
	Sig. (2-tailed)	.856	.	.842	.830	.081	.320	.772
	N	609	647	525	401	598	597	481
Security (2)	Pearson Correlation	-.161**	-.009	1	.063	-.176**	.029	.011
	Sig. (2-tailed)	.000	.842	.	.234	.000	.511	.827
	N	544	525	571	354	536	529	433
Alphabetization/Scholorization (3)	Pearson Correlation	-.037	-.011	.063	1	.042	.091	.056
	Sig. (2-tailed)	.456	.830	.234	.	.397	.067	.304
	N	409	401	354	433	405	408	338
Social Life (4)	Pearson Correlation	.042	.071	-.176**	.042	1	.191**	-.237**
	Sig. (2-tailed)	.295	.081	.000	.397	.	.000	.000
	N	615	598	536	405	654	602	484
Food (5)	Pearson Correlation	-.084*	.041	.029	.091	.191**	1	.092*
	Sig. (2-tailed)	.039	.320	.511	.067	.000	.	.041
	N	610	597	529	408	602	645	493
Water and Sanitation (6)	Pearson Correlation	-.014	-.013	.011	.056	-.237**	.092*	1
	Sig. (2-tailed)	.756	.772	.827	.304	.000	.041	.
	N	490	481	433	338	484	493	521

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Access to health and social services and location

		Available health and social services		
		Yes	No	Yes
Delmas	Count	69	40	109
	% within Location	63.30%	36.70%	100.00%
	% within Available health and social services	15.90%	11.80%	14.10%
Petion-Ville	Count	99	33	132
	% within Location	75.00%	25.00%	100.00%
	% within Available health and social services	22.90%	9.80%	17.10%
Tabarr	Count	52	27	79
	% within Location	65.80%	34.20%	100.00%
	% within Available health and social services	12.00%	8.00%	10.20%
Leogane	Count	14	25	39
	% within Location	35.90%	64.10%	100.00%
	% within Available health and social services	3.20%	7.40%	5.10%
Croix des Boukets	Count	35	15	50
	% within Location	70.00%	30.00%	100.00%
	% within Available health and social services	8.10%	4.40%	6.50%
Cite Soleil	Count	35	54	89
	% within Location	39.30%	60.70%	100.00%
	% within Available health and social services	8.10%	16.00%	11.50%
Port-au-Prince	Count	92	123	215
	% within Location	42.80%	57.20%	100.00%
	% within Available health and social services	21.20%	36.40%	27.90%
Carrefour	Count	37	21	58
	% within Location	63.80%	36.20%	100.00%
	% within Available health and social services	8.50%	6.20%	7.50%
Total	Count	433	338	771
	% within Location	56.20%	43.80%	100.00%
	% within Available health and social services	100.00%	100.00%	100.00%

Sig = 0.000 < α (5%) $\rightarrow$ the relation between Location & Access to available health and social services is significant.

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