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Articles

Born in Haiti: A Maternity Hospital in the Context of a Humanitarian Crisis

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Abstract

This is a report on the experience of implementing a mental health program in a maternity hospital and three mobile clinics in the city of Port-au-Prince. We started by listening to the difficulties faced by the national teams in their daily routines at the hospital and what they expected of a mental health program. The program was planned in a way to contemplate the perceived needs of the hospital teams as well as those of the target population, pre and post-natal women, within a systemic perspective. Thus the program covered the following aspects: training with the hospital team on communication and helping relationships, a series of speeches on mental health at the hospital, psychological treatment of the patients through counseling sessions, involvement of partners and families being assisted, support groups for peri-natal mourning, men's groups with the future fathers, psychoeducation in the mobile clinics, a survey of the social network in the city, psycho-social assistance and the introduction of relaxation strategies at the hospital. We concluded that in the context of a humanitarian crisis, as in the case of Haiti, a mental health program should contemplate different levels of need and take into consideration that health care professionals are also subject to the context of social stress. At the same time, the involvement of hospital teams in the process is fundamental to the success of the program.

Keywords: maternity hospital, Haiti, humanitarian crisis, mental health program, systemic perspective

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Introduction

This article is a report on the implementation of a mental health program in a maternity hospital in Port-au-Prince between 2008 and 2009 that was part of a mission developed by the medical humanitarian organization, Doctors Without Borders (MSF). Although the objectives of the program were predetermined in the job description, the details of the hospital context guided the implementation process in an unexpected direction in which the involvement of the national hospital team became fundamental to the success of the program.

On arrival in Port-au-Prince we had the impression that Haiti did not seem to have the level of urban violence of years past that had called for the need of MSF projects. In spite of the constant parade of MINUSTAH[i] troops, the recent past was unrecognizable in daily routines. The colors of the tap taps and the musical rhythms reminded us that we were in a Caribbean country with a strong and lively personality in spite of the history of political conflicts and degrading misery that intensified as one moved farther into the slums. However the political instability persisted and peace was maintained without the social infrastructures to sustain it, such as employment, education and free efficient public health. Although the armed groups had apparently been broken up, criminal activity persisted

in kidnappings, break ins in poor neighborhoods and sexual violence against women, such that urban violence statistics were high, with impacts on the population similar to those produced during armed conflicts[ii].

Among the impacts was the fact that many pregnant women feared looking for a hospital in the middle of the night as a consequence of the lack of security in the streets (Doctors Without Borders [MSF], 2008). The social and political instability, mass unemployment and lack of perspectives caused a feeling of desperation in the population in relation to the future of Haiti, balanced by hope in God, which is written everywhere in créole. In fact, Haiti was going through a humanitarian crisis generated by the interaction of all the above mentioned factors and aggravated by recurring natural catastrophes such as hurricanes and the earthquake in 2010 that have further reduced quality of life and broken down social networks (Sutter & Melo King, 2012). Among the symptoms of this breakdown were weakening of the family – as a reference group for psycho-social protection, – and extreme sexual violence against women[iii].

To combat the high levels of maternal mortality in the country – the highest in the western hemisphere (630 per 100.000 births) –, in 2006 MSF-Amsterdam started an emergency obstetrics program with the foundation of the Jude-Anne Hospital in an old building in the Delmas district. Later in February, 2009, they constructed a new hospital with more adequate installations in the Solidarité district, which unfortunately was damaged by the earthquake. At that time, Port-au-Prince had a population estimated at 2.5 million inhabitants and an average of 5,500 births per month, of which half were carried out by traditional midwives. Generally women did not have access to pre-natal or any medical help while giving birth due to the precarious nature of the public health system, economic barriers or difficulty in locomotion (Doctors Without Borders [MSF], 2008). The Jude-Anne Hospital had 63 beds, two surgical theaters, one pediatrics room, one laboratory, one room for blood donating, one for VCT (Volunteering Counseling Testing for STD-AIDS), one OPD (Out Patient Department) and one room for psychological counseling. The national hospital team was composed of 300 workers. In addition to this, there were 3 mobile clinics in the Solino, Péle-Simon and La Saline slums, where pre-natal and VCT were carried out. Between March 2006 and February 2009, when the hospital was transferred to Solidarité, 44,693 patients were admitted. The most common obstetric complications seen at the hospital were: severe preeclampsia, eclampsia, birth obstructions, hemorrhaging and abruptio placentae.

At the maternity ward it became even more evident to what point the population had become abandoned when we saw the conditions of the female population, which represented the most vulnerable sector of society, traditionally supported by males. Pregnancy and births were truly risky and bringing a child into the world was rarely a happy event. However Haitians continued to have unplanned children due to the fact that this was frequently the only strategy they possessed to keep a man by their side, which was synonymous with “survival.” For a Haitian man, having a child is an important part of affirming his masculinity and a woman capable of having children will probably have a place to live and eat. A social network of dependencies where children are used as part of the negotiations is the result of the lack of perspectives and opportunities for women.

The recognition that medical assistance is not enough in cases where patients live in precarious conditions with psychic suffering (Bradol, 2003) has led MSF in the last twenty years to include psycho-social assistance in its projects. In the specific case of the group assisted by the Jude-Anne project, we had a population that was not only at risk due to the high incidence of complications during pregnancy and consequently maternal mortality, but also due to the social vulnerability that has caused these women to be victims of abandonment and domestic and sexual violence with grave repercussions to the mother/infant relationship. These totally unprotected women and

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adolescents needed psycho-social support to help them face critical situations as well as psychological support when facing medical complications. On the other hand, as a consequence of the maternal vulnerability, we had an at risk neonatal population that needed psycho-social attention as well because they were lacking in adequate care and breastfeeding due to maternal rejection or lack of information or family support.

Implementation of the Mental Health Program

The Hospital Context

In addition to the difficult social context in Haiti, the hospital context was also very complex. There was an internal crisis in the hospital due in part to inter-sectoral conflicts. A complaint circulated among the national team supervisors and expatriate professionals that the patients were not well treated, particularly by the midwives. The basis for this inadequate treatment came apparently from prejudice in relation to these women - the majority of whom were from the slums and were extremely poor - because they arrived at the hospital unclean[iv]. They were also not accustomed to gynecological examination and were accused of not “cooperating” with the midwives. The result was that the afflicted midwives lost patience when the patients didn't allow them to carry out the necessary procedures.

Since the inauguration of the hospital a psycho-social program was up and working, guided by the Haitian psychologist that included counseling for patients and receiving victims of sexual violence who were later sent to the MSF - France unit. Despite her dedication, she did not receive the necessary recognition of the value of her work by the national hospital staff. We understood that we could not adequately implement the mental health program without the acceptance and co-participation of the other professionals at the hospital.

To do this and to have a little more clarity on the difficulties that the teams faced in their daily routines, we decided to organize meetings in the first month of work with the different teams with the objective of simply listening to them. In this way, through listening, we were able to determine the way we would put the pre-established objectives of the program into practice.

Team Meetings

In a meeting with the supervisors we proposed meetings with the different teams, emphasizing that participation would be voluntary and confidential. We organized the meetings during different periods to guarantee the largest number of participants and ended up having 16 meetings with participation of 76 people from all the sectors of the hospital (doctors, nurses, nurses' aides, operation room nurses, midwives, obstetricians, anesthesiologists) and from general services (doormen, stretcher bearers, groundskeepers, cleaning people, receptionists).

The objectives of the meetings were to find out: a) what their perceptions were of the hospital, the patients and their jobs; b) what they expected from a mental health program; c) what themes they wished to have addressed in future seminars/training sessions. Although the number of participants was less than 1/3 of the professionals at the hospital, those who participated were really interested in contributing. So we were impressed with the solid participation of the doormen and stretcher bearers, possibly because they felt more pressure from family members at the entrance to the hospital or from other staff at the hospital asking for their help in transporting patients. However the midwives were the group that participated the least. At the meetings many subjects came up with the objective of understanding how they perceived the work environment and the relationship with the patients.

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The people that came really wanted to be heard and felt included in the planning of our program. In welcoming them, we also felt accepted and began a cooperation that proved to be quite fruitful in the following months. It was fundamental for us to consider the suggestions that the different teams made in constructing our work strategy. Below is a synopsis of the most important points for the objectives of this article:

Patient Perception

Mainly among midwives and receptionists the patients were perceived as ignorant, aggressive and uncooperative people who didn't understand admission criteria, the notion of urgency and medical procedures. The midwives pointed out the difficulty of dealing with uneducated women, without notions of hygiene who left them exhausted as is related in this testimony: “Cooperation is impossible during labor. The women do whatever they want and don't control themselves.” They say that sometimes they were firm with the patients in order to save their lives or their babies' lives and this was interpreted in the wrong way. But the level II nurses (where the women stayed after giving birth or after being operated on) did not have any difficulty in getting patients to cooperate in general, which made us think about the possible influence of the emergency situation and the tension during labor and the quality of relationship between nurses/midwives and the patients.

Difficulties at Work and Inter-Sector Conflicts

There was a general complaint about the relationship of authority among the sectors of the hospital, principally between the hospital staff and the general services staff. The latter felt they were considered to be of less professional value who were disproportionately blamed when things went wrong. They also affirmed that during meetings there was no place for them to express themselves. At the same time the nurses from the operation block felt like they were not well received by the other sectors.

The doormen complained about the enormous pressure they suffered at the entrance to the hospital, having to keep family members out as well as the way they were treated by the nurses. The stretcher bearers and cleaning people also pointed out the fact that nurses did not treat patients and family members very well. The doctors added that the teams were not prepared to deal with patients and that is why relationships became tense.

The nurses in the OPD said that sometimes they cared for a patient with family problems or one whose baby had died and they did not know what to say. They also said they did not know how to deal with women who had many personal problems whose labor was particularly difficult.

Expectations

The main expectations from a mental health program were:

- Prepare women for labor/giving birth. Prepare pregnant adolescents for the responsibility of their future child. Educate adolescents to not use self-abortion as a means of contraceptive. Work on the mother/baby relationship. Work on some of the myths about breastfeeding.
- Prepare professionals for developing the patience and sensitivity to give better care to the patients. How to better approach patients and family members. Help to educate women about traditional treatments that worsen their state of health.
- Accompany all patients who have undergone serious operations. Give attention to mothers of deformed babies.

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- Set up a space for listening to professionals who have suffered an accident at work (like being stuck with a needle) or who have had a patient die. Set aside a moment for the teams to discuss conflicts.

Suggested Themes for Speeches

How to manage stress and exhaustion; how to have patience and courage; the art of living and relationships; how to dominate fear and manage people's anger; how to give support for a woman in mourning; interpersonal and helping relationships; what to do with women who can't stand the pain and don't want to cooperate; violence and health; how to prevent post partum psychoses; how to help a patient feel confident; how to deal with difficult relatives; how to convince relatives that a patient is sick; what attitude to take with relatives of patients who have died in the operating room; how to tell someone that their baby has died.

Thus, after this survey, it became clear among many demands that we would have to work in two directions: the psycho-social needs of the patients and the improvement in the quality of care and the relationship between teams. In our meetings we sought to disseminate the idea that the concern with mental health is not just relevant to psychology professionals but rather is the concern of all those who work with human beings.

Training

In order to respond to difficulties experienced by the national staff in relation to the patients and their family members we organized an eight hour training seminar on “communication and helping relationships” for all the teams, without restrictions, including doctors. The training seminar sought to sensitize the teams to the importance of good communication and the quality of care in order to obtain better results with the patients and incorporate the humanitarian purpose of the project. The training seminar focused on the following content:

- Be conscious of the different means of communication and the impact of communication on other people's behavior.
- How to establish non-violent communication.
- Communication in relation to help.
- The humanization of health care.

We decided together with the project coordinator that participation would be voluntary and that the event would be held outside the hospital in an all day format. We put together seven groups with a total of 118 people participating, including 8 doctors, 32 midwives, 22 nurses, 5 operating room nurses, 4 pediatric nurses, 2 VCT nurses, 6 aides, 9 stretcher bearers, 6 receptionists, 5 cleaning people, 2 cooks, 3 laundry people, 5 doormen, 2 grounds keepers, 2 sterilization agents, 1 logistical assistant and 2 expatriates. The last seminar was carried out completely in créole for those who were not comfortable in French.

In the first part of the seminar, the intention was to mix up participants from all the different teams so as to promote more integration and better comprehension of the difficulties of each team in its day to day work. Thus, in each group we had representatives from all the sectors of the hospital. In order to explore the situations that the teams commonly faced, we started the seminar with dramatizations of the types of situations experienced at the hospital. In the dramatization each mini-group had to put together skits and distribute acting roles to those present. In a very spontaneous way, we saw doctors playing doormen, midwives representing patients, cleaning people playing midwives and stretcher bearers representing doctors and so on. By way of the dramatizations people could understand how they acted in daily situations, such as “non-cooperation” of a patient, conflicts with family members,

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the rude or insensitive way that the receptionists or midwives treated the women, the stress on entering the hospital, etc. Next we asked each group to redo the scene, but this time presenting an alternative way of dealing with the situation that was more appropriate or caring, depending on the theme taken up. Through the scenes presented, the group had the opportunity to see "from the outside" and become sensitized to the theme of communication and the helping relationship. So we worked with reference to the theory of pragmatic communication (Watzlawick, Beavin, & Jackson, 1986), and non-violent communication (Rosenberg, 2003)[v].

In the second part of the seminar we focused on the concepts of the helping relationship and the humanization of care as evolutions of medicine within the humanized perspective of health care, which include giving value to the psychological dimension through care and empathy (Deslandes, 2006). The objective was to raise consciousness about the fact that the psychological state of the patient influences the acceptance of and involvement with the treatment that she receives, such that the humanization of care is an indispensable complement for the efficacy of medical procedures. To achieve this it is necessary to have a double focus: the physical as well as the emotional condition of the patient and careful communication with her. Our objective was to show that "fighting" with patients was not going to get them to cooperate, but rather listening to them, conversing, understanding what was happening to them and above all, explaining each procedure. In the end we worked with case studies, always in mixed groups.

The evaluation by the groups was very positive, despite having very little time. To facilitate the assimilation of the themes covered we put together a booklet that all the participants received. Surprisingly, the midwives were the group that participated most in the seminar in spite of their initial resistance. However this team needed another training seminar planned by the expatriate supervisor in which professional ethics and humanized births were covered.

To complement the training and reach more professionals that couldn't participate in the seminar, we started a series of speeches at the hospital once a week on the themes that the teams suggested to us and others that we felt were pertinent. The main themes covered in the speeches were the following: a) the psychology of pregnancy; b) neo-natal mourning; c) sexual and domestic violence; d) post partum psychiatric disorders; e) teen pregnancies; f) death and the family; g) suicide; h) post traumatic stress; i) dealing with stress at work; j) the effects of poverty on the psyche. This last theme was included to do away with the prejudice that existed towards the poorer women. Another reason for including the speeches in the daily routine of the hospital was to sensitize the professionals to the psychological needs of the patients and to the work of the psycho-social team because, although their service was constantly solicited, their advice was not always followed. The attendance at the speeches was very good, with an average of seven participants at each one, considering that they occurred during work hours. People really showed interest in the themes and the possibility of having workers from different sectors interacting in debates and discussions on situations experienced at the hospital made the situation even more beneficial. As the themes were repeated after a few weeks, the professionals had the opportunity at some point to participate.

Finally, in order to get all the teams definitively involved with the mental health care of the patients, we created forms for sending patients to psycho-social services that were put out all over the hospital and the OPD. The idea was to help the hospital staff to recognize the signs and need for psycho-social support. The nurses and doctors easily incorporated the use of the forms which were collected twice a day (see the model for the forms in the Appendix). With the forms the referrals became more organized, avoiding the loss of information or the referrals themselves, which generally happened a lot during the changing of shifts.

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Working With Patients

The counseling work and psycho-social support in place since the inauguration of Jude-Anne continued to be carried out. But the hospital patients were cared for in beds without any privacy at all. The psychological room was in the OPD building, far from the hospital. We were then able to create a small therapeutic setting on level II where we could see families. Below are the most common situations that required psycho-social support:

- Medical complications: loss of the baby (stillborn baby, neonatal death, spontaneous abortion); precious pregnancy; self abortion; ectopic pregnancy; women who have had a hysterectomy.
- Psychological/psychiatric disturbances: women with baby blues / post partum psychosis; cases of anxiety.
- Problems in the mother/baby relationship: rejection / abandonment of the baby; difficulties in breastfeeding; babies with deformations.
- Abandoned patients / lack of family support.
- Teen mothers.
- Cases of domestic and sexual violence.
- Refusal to accept treatment (generally inducement of labor due to preeclampsia)
- HIV positive patients.

The main complaint was related to mourning, due to stillborn babies and neonatal deaths (41%), followed by anxiety due to concern about breastfeeding and the baby's health (18%), followed by family related complaints (9%), mood (9%) and somatic complaints (8%). By the high percentage of complaints related to mourning, one can perceive how fragile the health of pregnant women and their babies is in Haiti, such that being born and surviving in this context is a true adventure that begins during gestation.

With so many demands, we introduced other possible areas of activities, such as giving support to families confronting the death of a baby or its mother. The need to increase the possibilities of intervention with patients was clear and gradually a systemic approach was implemented, including assisting patients' partners or family members in the therapeutic setting when necessary and possible.

Family Inclusion

Many of the problems that the women suffered, in addition to those related to giving birth and puerperium, were due to questions of relationship, in the case where they are totally dependent on other people for survival. A pregnancy or loss of a baby can signify the loss of this support, since they can be abandoned for one reason (if the family doesn't want another mouth to feed) or another (if a man doesn't want a woman who is not capable of giving him a child). Some complaints are related to the participation of family members in the drama experienced by the patients. Mutual accusations in which women are frequently targeted can raise stress levels and aggravate the trauma as for example when a husband blames a woman for loss of a baby. Family resources need to be discovered and negotiated. The family also can be an important ally in accepting treatment, as in the case of a patient with tuberculosis. Some women do not want to accept inducement of labor in cases of preeclampsia if their partners do not authorize it. For all these reasons, working in the perspective of an individual can be frustrating. We need to include the family in one way or another, principally when family ties are fragile due to the impact of misery in people's lives.

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Delivery Room

With the double objective of aiding delivering mothers who are in prolonged labor and give support to the midwives, we began to participate in the delivery room whenever necessary, that is when a woman was very tense or suffering a lot. Our role consisted in affectionately supporting the woman giving birth, calming her down, teaching her to breathe to help in pushing the baby out, being by her side so that she could feel more secure, considering that the women entered alone when they were ready to give birth. It was interesting to observe that the soon to be mothers readily accepted our help, especially the first time mothers, and the babies seemed to be born more rapidly after the mothers felt the support.

Mandalas and Music

The move to Solidarité, in February, 2009, with larger spaces than those of Jude-Anne, opened up new possibilities for the mental health program. We began to give more attention to patients who were admitted for longer periods of time. To improve the spirits of these women we introduced relaxation strategies to produce psychic well being. As most Haitians are fond of colors, we distributed pictures of mandalas for the patients to color. The level of acceptance was almost total and they spent hours at the task. The benefits of drawing and painting for the psyche are well known in the area of art therapy and mandalas are special drawings that have a therapeutic effect on the state of mind (Fioravanti, 2011). Soon doctors and expatriate professionals also wanted to paint mandalas and it was very interesting to observe how everyone got involved.

In carrying out an older project of a Congolese expatriate nurse, we introduced music on level II for relaxation in order to help in the recuperation of the patients. Although the nurses resisted a lot in the beginning because the music was totally different from local music, the patients loved it and said that it helped them to not think about their problems. We also bought story books for the few women who could read and had to spend many days in the hospital. The idea was to improve the spirits and help in the recuperation of these patients, who often came from very difficult realities.

Peri-Natal Mourning Group

Since the greatest number of patients came to us due to spontaneous abortions, stillborn babies and neo-natal deaths, we started a therapeutic group (groupe de parole) at the OPD on mourning with post-natal women. The objective was to offer a support space for listening and sharing with mourning women, especially those who felt alone and misunderstood in the normal manifestations of the stages of mourning. According to Cerutti and Defey (2001), the work strategy for peri-natal loss should be based on an attitude of support that contributes to the lifting of blame and overcoming the agitation and anguish that correspond to the first stages of mourning. In addition, women who suffered successive losses were common at the hospital, as were women who had had a hysterectomy at a very young age. After the psychoeducation sessions we invited women who wanted to participate and generally there were four to six women every day. The groups helped us to better understand the feelings of these women and take stock of the trauma that they experienced with the loss of their baby or their uterus. Normally, in the hospital bed, these women did not express their pain and many didn't want to speak about the subject, giving a false impression of indifference. We did not see this in the groups. Although the reaction to death in Haiti is very dramatic, it seems that mourning is blocked by a cultural norm which prohibits the expression of sentiments. As the Haitian writer Danny Laferrière (2011, p. 161) said, “En Haiti on se moque brutalement de vos angoisses”[vi], maybe as a way to develop resilience. Considering that denying the expression of pain of a loss is an obstacle for the mourning process (Bowlby, 1985), the groups became an interesting therapeutic strategy because when

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in them, women could cry, share sad stories and receive the support that the majority didn't get from their families. We knew that we were breaking a cultural rule, but it seemed like it was a relief for those who voluntarily participated.

Conversation Circles With Future Fathers

Some women were accompanied by their partners or husbands who waited outside our mobile clinics for our patients. As they spent hours at a time waiting with nothing to do outside, we had the idea to use their presence to help us. Thinking systemically, we considered it important to include the male population in our approaches, mainly because in Haiti the men hold power in most decisions and frequently we received pregnant women who had been victims of domestic violence. We also considered it important to include the fathers in the gestation process and in caring for babies. As a strategy we invited these men to talk about the pregnancy of their partner, paternity or any other doubts and concerns they may have had. The invitation was always made by the male Haitian psychologist, who was included in our team so that they would feel more comfortable. We met with the men in an improvised corner of the mobile clinic - generally a space given to us by the community - and started to talk about the experience that they were having with their partner's pregnancy. They usually accepted the invitation immediately because they felt overburdened by worry about the birth, with their partner's emotional changes and consequent conjugal conflicts. The older members in the group gave advice to the younger ones and we acted as respectful facilitators of the dialogue between them, intervening only when necessary. It was very interesting to get this look at the men because we were made aware of many conjugal conflicts that unfortunately sometimes ended up as physical aggression. In such a difficult socio-economic situation, neither living as a couple, nor paternity, nor maternity are easy situations to deal with, demanding emotional energy from people that was rarely available. But we also met men who were sensitive and concerned about their partners.

Psycho-Social Attention

Every month we had cases that required psycho-social intervention. Generally they were cases of abandoned women who didn't receive visits at the hospital or who didn't have anywhere to go after giving birth. As was said earlier, the birth of a baby could be a motive for a family to expulse a woman or a partner leave her to her own luck. So, we heard a lot of very sad stories. Some mothers didn't have clothes for their newborns and not even for themselves. Others were victims of domestic violence. Sometimes we had to bring mothers who had just given birth to the neighborhoods where they lived and negotiate with their families and neighbors to accept them. In the slums, the loss of the natural bonds of the community leads to abandonment and suspicion. The result is almost always a social disaster, especially for these women who don't have anywhere to go and are sent away from their homes with a newborn baby in their arms. Some go back to the hospital to ask for help. For postpartum eclampsia women who have temporarily lost their memory, the task was to locate the family. So, this was an important activity because we couldn't release these women who were extremely vulnerable. In order to be able to respond minimally to these social cases, we had a small monthly budget.

Survey of the Port-au-Prince Social Network

For the social cases, those of sexual and domestic violence, abandoned babies and people living with HIV-AIDS who needed to be referred to other governmental and non-governmental institutions, we carried out a survey of the social network of Port-au-Prince. Unfortunately we didn't find any institutions that cared for abandoned women or that supplied milk for babies who were less than six months old in the cases of mothers who were not able to breastfeed. Although Haiti is known as the “Republic of NGOs” (Kristoff & Panarelli, 2009), due to the great

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number of them in the country, one gets the impression that many of them do not respond to the needs of the population, possibly due to the bureaucracy or inefficiency of service, or possibly due to the difficulty for the women to be included in the social programs because they don't have identification documents, as poor people in Haiti rarely have any type of documents. Despite having an available network, we had to deal with a great deal of frustration over social cases that dragged on without a solution and sometimes ended in tragedy.

Psychoeducation

After observing the needs of the women we introduced psychoeducation in the OPD and the mobile clinics. Many expecting mothers were anxious about their pregnancies or worried about their future newborn and the impact of the pregnancy on their conjugal relationship, which is to be expected in light of such an enormous emotional mobilization in this important step in a woman's life (Soifer, 1980). We also observed that the pregnant adolescents did not seem to be concerned about the impact of risky behavior on the pregnancy, such as using drugs. Because of this the main theme for psychoeducation was the psychology of pregnancy, where we addressed the different stages of pregnancy with the physical and psychological changes and the care needed as well as the emotional reactions of the post-partum period. Another problem we found was the rejection of some mothers to breastfeeding or the inability to do it, as if they had never had a positive model for doing it. We discovered that there are prejudices towards breastfeeding that put the baby at risk since mothers do not have money enough to buy formula for them. The baby can be seen as a vampire who sucks the milk/blood from the mother. A mal-nourished mother can believe that she will become even weaker by breastfeeding, or that the milk produced in the breasts can rise up to the head and drive the woman crazy (generally this is the explanation for the confused state of postpartum eclampsia). Another extreme is when the woman refuses to breastfeed because she doesn't want to “damage her breasts,” which left us perplexed since there weren't any other alternatives for these women. The origin and reach of these prejudices certainly deserve more detailed research.

We were also concerned about the quality of the bond between mothers and babies and the prevention of mistreatment. The indifference of many mothers to their babies was apparent, even in the delivery room right when the baby was born. On level II, where women stayed with their babies by their sides, we commonly saw newborns crying without being comforted or put on the mother's breast and sometimes even receiving a slap. These scenes truly left us worried and many questions came up. We knew that one principle of Haitian education is that life is hard and it is necessary to get used to this early, and this justifies disciplining children with severe corporal punishment. We also knew that it must be very difficult to be happy with the birth of a child when there is nothing to eat at home, your partner has abandoned you or the baby is the result of rape. But to hit a newborn infant is something unthinkable. For this reason we included talks about the mother/baby bond, breastfeeding and the quality of care for the emotional and cognitive development of the child in the psychoeducational sessions (this theme had already been suggested by the Haitian pediatrician in our meetings).

Of course psychoeducation was very polemic because we were going against local culture. But as there are always some caring mothers who breastfed their babies and were against hitting them, the debate was having some effect. So much so that after the sessions some mothers came to talk to us about the development of their babies. However the real proof that the psychoeducation sessions were having an effect came with the visible reduction of mistreatment at the hospital.

So, the complaint by the midwives about the “ignorance” of the population seen at the hospital (women from the countryside or living in slums) although not very polite and reinforcing of certain prejudices, was not completely

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without basis. What we came to understand was that the “lack of education” was in fact, a form of socialization congruent with a cultural tradition that served other purposes, principally that of survival. And for good or bad, that is how the Haitian people have resisted. We also understood that this form of socialization has been damaging to defenseless people like the babies and even for the mothers. So, the decision to approach these themes was not made by exercising a symbolic violence - knowledge of the white elite taking precedence - but to give people an opportunity to conceive relationships in a different way. As the ethno-psychiatrist Adalberto Barreto said[vii], therapeutic action is that which changes certainty to doubt.

Another point that caught our attention was the way in which the mothers held their babies, never close to their bodies, but rather with their arms stretched out. At feeding time, the mothers also didn't bring the babies to their breasts, but rather they brought their breasts to the babies who laid on their laps as they bent over them. We don't know where this practice originated, but it didn't seem comfortable for the mothers or comforting for the babies, without being held close to the bodies and the arms of their mothers. It was also difficult to breastfeed in this way. For those mothers who had difficulty breastfeeding, we began to show a different way of doing it, respectfully, which was to bring the babies up to their breasts. We also showed how to calm the babies down and burp them. The Haitian psychologist, who was already a father, even taught an adolescent mother to change her baby's diaper. All of this made us stop and wonder: where are the mothers of these mothers and the trans-generational teaching of how to care for a baby? We found no answer. But we included in our practice giving attention to first time mothers who needed help.

Violence against women was another serious problem. Our patients were continually exposed to conjugal and sexual violence which resulted in risks for the pregnancy or undesired babies. It is estimated that 20% of pregnancies are the result of rape (Doctors Without Borders [MSF], 2008). At the hospital it was not rare to receive a pregnant mother with a history of abuse. But we also came face to face with a strange reality: according to reports from Haitian professionals who worked with education and communication in the communities, frequently women didn't consider attacks by only one man or by someone they knew to be rape. They also thought that their husband had the right to sex whenever he wanted, or that he could punish the woman if she did something wrong. The punishment could be to beat her or not give her food. As in other countries where levels of gender violence are high, research shows that among the “justifications” for a husband to beat his wife is the wife not carrying out her domestic or marital obligations (World Health Organization, 2005; World Health Organization/London School of Hygiene and Tropical Medicine, 2010). At the same time the educational level is low in those cultures where women themselves see gender violence as legitimate. Haitians in the poorest of neighborhoods didn't even seem to be conscious of their rights as human beings and were submissive to a patriarchal culture, probably originating in Africa, in which the men are the absolute rulers on whom women depend for their survival even though poverty affects both genders. Because of this we included the theme of gender violence in psycho-education, covering the various forms of violence (physical, psychological, sexual) as well as factors that prevent violence and protect women. This was by far the theme that mobilized the most debate, including the participation of the men who attended. We believe that talking about different types of violence to which they were exposed could help them to identify and not legitimize the violence in their lives. As always, after the psychoeducation session, some women came to talk to us about an abusive situation they were experiencing.

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Final Considerations

Dealing within such a complex and heavy reality is in fact, not simple. It is necessary to evaluate and think simultaneously on many different levels, knowing that the picture is never completely complete. On the question of maternity in Haiti, many questions remained without answers due to the contradictory way in which they were presented: women mourning the death of their babies next to women who were completely indifferent to their newborns. How much of this behavior is caused by culture, poverty or by both? How much does a humanitarian crisis affect maternity, not only with respect to the morbidity or maternal mortality, but in the quality of the mother/infant relationship?

Many things happen at the same time in a hospital, especially a maternity hospital. The mysteries of life and of death meet there. People can be joyful or profoundly sad. However, in the context of a humanitarian crisis, everything acquires a larger dimension and humans are taken to their limits: from total abandon to the most unexpected solidarity; from the expression of injustice of the world to the possibility of accessing what is best in people. We need to remember that the hospital staff is equally affected by the crisis and also needs attention. A mental health program should consider these factors and count on resources that still exist even where there appears to be no solution. It is possible to create niches of humanity, as Lachal (2003) affirms, and involve all the actors in this creation. It is also necessary to be sensitive in order to distinguish between what is cultural and therefore deserving of respect and what is universal because it refers to the preservation of human dignity. And in the interface of these two worlds, to be able to dialogue in the language of love, which is always universal.

Notes

i) Minustah: United Nations Mission for the Stabilization of Haiti, in country since 2004.

ii) According to Ponsar, Ford, Van Herp, Mancini, and Bachy (2009), in research carried out in two Port-au-Prince neighborhoods in 2006, “The humanitarian consequences of urban violence are similar to those of armed conflict: people are killed, injured and displaced; infrastructure is damaged or destroyed; access to health care is restricted. In Cité Soleil and Martissant, civilians were exposed to violence in ways that caused everyone to become a victim; such a situation is comparable to contexts of civil war where the line between combatant and non-combatant is often blurred.” (p. 5).

iii) Although it is hard to paint a precise statistical picture of the sexual violence situation in Haiti, research shows that between 2004 and 2005, there were 1680 sexual attacks on women and girls per 100,000 inhabitants per year, according to Lucchi (2010). In 2008, the MSF France hospital in Port-au-Prince received an average of 40 rape victims per month, considering that there were other organizations that also helped victims.

iv) In fact, the stigma of women from the slums existed for other professionals in other health units in the capital and was one of the factors cited in explaining why pregnant women didn't seek out hospitals when giving birth (Doctors Without Borders [MSF], 2008). Considering that half of the population of Port-au-Prince lived in extremely miserable slums, it is very strange that this prejudice was widespread among professionals who worked in the public health arena.

v) According to the Palo Alto group, all behavior has a message value and has a pragmatic effect on the behavior of others. Non-violent communication avoids messages that blame others and provoke a defensive response in others.

vi) “In Haiti, one brutally mocks their anguish.” (loose translation).

vii) Personal communication.

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Appendix

SERVICE PSYCHOSOCIAL		**Fiche de référence - Hôpital Jude-Anne**		
Nom de la patiente. ……			Date…../……/……	
Référé par ……			Section: ……	
Veuillez cocher le ou les cercles appropriés:				
Complications médicales	**Problèmes relation mère-bébé**	**Troubles psychologiques et psychiatriques**	**Victime de violence et privation**	**Problèmes comportementaux et autres conditions**
o Mort néonatale o Avortement spontané o Avortement provoqué o Grossesse précieuse o Grossesse ectopique o Hystérectomie o Confusion post éclampsie	o Rejet du bébé o Bébé mal formé o Problèmes d'attachement o Difficulté d'allaiter o Souci envers bébé o Maladroite avec le bébé o Maltraitance du bébé	o Tristesse o Pleur facilement o Détresse o Peur o Panique o Soucis/anxiété o Douleurs inexpliquées o S'inquiéter pour tout o Pensées / paroles désorganisées o Illusions/délires o Hallucinations o Pensées liées à la mort	o Violence sexuelle o Violence domestique o Violence sociale (insécurité dans le quartier) o Abandonné par le conjoint / la famille o Aucun soutien social o Aucune ressource financière o Sans logement	o Non-collaboration o Agressivité o Comportement bizarre o Agitation o Filles mères o Décès à l'hôpital o Problèmes avec la famille
Explication supplémentaire:				

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