Strategy for providing integrated mental health/psychosocial support in post earthquake Haiti

Boris Budosan & Rachel Frederique Bruno

The recent earthquake in Haiti exposed all the weaknesses in the mental health care system existing prior to the earthquake. This paper describes the strategy developed by the Dutch nongovernmental organisation Cordaid for providing integrated mental health and psychosocial support in Haiti after the earthquake. The strategy aimed to address mental health and psychosocial needs in the early recovery and reconsolidation phases, and to build mental health capacity of community level and primary health care providers. This would result in the establishment of a referral system between the community and health care sectors. The results of the implementation showed that mental health trainings were a feasible intervention for Haiti, but so far they have not yet resulted in change of practice of primary health care workers, and the goal of a referral system is still in an embryonic phase.

Keywords: community level workers, earthquake, Haiti, mental health, primary healthcare, psychosocial support, training

Introduction

On 12 January 2010 Haiti was struck by a catastrophic earthquake. Its epicentre was near the town of Léogâne, approximately 25 km (16 miles) west of Port-au-Prince, Haiti's capital. An estimated three million people were affected by the quake. According to the information from the Interior Ministry of Haiti, as of 10 March 2010, 222,653 people were registered as dead, and 310,928 were wounded. More than 1.5 million were in need of basic assistance, and 660,000 people were displaced. An estimated 250,000 residences and 30,000 commercial buildings had collapsed, or were severely damaged.

Background: mental health needs in Haiti

The capacity of the mental health system prior to the earthquake in Haiti was weak, but the available data on the number of mental health professionals differ depending on the source. In the Mental Health Atlas (World Health Organization, 2005), no data were available. A 2003 PAHO/WHO report counted 10 psychiatrists and nine psychiatric nurses working in the public sector, and two government psychiatric hospitals in Port-au-Prince (World Health Organisation, 2010a). These figures are contested (Lecomte and Raphael, 2010). According to Clouin (2009), before the earthquake there were 23 psychiatrists, 10 psychiatric nurses in public sector, approximately 50 psychologists (at Master's level) and an undetermined number of social workers in 2008. According to the World Health Organization (2010), most of the services provided by mental health professionals were in the private sector, and based primarily in Port-au-Prince. Mental health services outside of Port-au-Prince were practically non-existent. At the country's second largest hospital, l'Hôpital

Universitaire Justinien, in the city of Cap-Haïtien in the north, psychiatric services were limited to monthly visits by a psychiatrist from Port-au Prince (World Health Organization, 2010a). Before the earthquake, there was only one psychiatrist providing services in the south of the country, in the town of Les Cayes (personal communication Dr Caroline Coicou, 22 April 2010).

The availability of follow-up community mental health treatment was also very limited, and regardless of the type of illness, family members were usually the first to be consulted regarding treatment and advice. According to the World Health Organization (2010), traditional psychiatric drugs were generally available on the market before the earthquake. Only a small number of people with private health insurance were eligible to receive a reimbursement for the purchase of medication.

There is no epidemiological study on the prevalence of mental health problems in Haiti (Caron, 2010). The World Health Organization (2010a) estimated the distribution of diagnoses seen at a psychiatric hospital in Haiti (prior to the earthquake), as follows: schizophrenia (50%), bipolar disorder with mania (30%), other psychoses (15%) and epilepsy (5%). This breakdown is not dissimilar to in-patient populations in other countries, but does not show the actual prevalence of mental disorders within the community. Pre-earthquake studies found high levels of symptoms of posttraumatic stress disorder (PTSD), depression, anxiety and somatic problems in victims of conjugal violence (Benjamin, 2008). Clouin (2009) reported that the majority of beneficiaries of a nutritional programme suffered from depression after the 2008 hurricane in Gonaive. Caron (2010) uses a conservative estimate of 190,000 people (5% of 3.8 million inhabitants of Port-au-Prince) suffering from symptoms of posttraumatic stress after the 2010 earthquake.

Traditional mental health services

A very large number of Haitians, especially those of lower education and economic status, made use of traditional practitioners, i.e. herbalists (*dokte fey*) or religious healers, i.e. *houngan* and *mambo* (male and female voodoo priests) when faced with mental problems. Also, Christian churches in Haiti help people cope with mental and emotional problems (Bijoux, 2010). Dispensaries, religious health facilities and herbalists were by far the most common choice for treatment (80% of all consultations before the earthquake), since they were less expensive and more easily available. Hospital clinics and other types of healers were physically less accessible and their treatments more expensive. Patients therefore referred to them less frequently (only 6% and 5% of consultations, respectively) to treat more uncommon and severe mental problems (World Health Organization, 2010a).

In recent years, Haitians have mobilised a network of community resources to sensitise the population to social and health issues related to various problems, such as violence against women, HIV/AIDS and children's rights. These grassroots organisations have also served as self-help and support groups for people facing severe life events and ongoing stress (World Health Organization, 2010). Many of these organisations were affected by the recent earthquake in terms of destruction of their infrastructure and loss of lives of their staff, but most of them, with the help of international community, resumed their activities to some extent very soon after the disaster. Also, Christian churches in Haiti helped people cope with mental and emotional problems (Bijoux, 2010).

Mental health & psychosocial support (MHPSS) after the earthquake

A Mental Health & Psychosocial Support (MHPSS) Working Group was established within the cluster system in Haiti in the aftermath of the 2010 earthquake (Schininá et al., 2010) which issued a Guidance Note for MHPSS based on the *IASC Mental Health and Psychosocial Support Guidelines in Emergency Settings* (Inter-Agency Standing Committee, 2007). According to Lecomte (2010a), there were about 100 nongovernmental organisations (NGOs) active in mental health in Haiti after the earthquake, offering 17 different modalities of MHPS intervention. Various models of providing MHPSS were applied including: a) local and foreign mental health professionals providing short-term direct clinical care for mental health problems, including psychiatric disorders, and training lay volunteers, local psychologists and primary health care (PHC) physicians on MHPS issues; b) organisation of child friendly spaces; c) individual and group psychological support; d) recreational activities for beneficiaries; and e) advocating for mental health issues (Mental Health and Psychosocial Support Network, 2010). Based on the review of relevant literature (both international and local), extensive field based assessments (described below), and the donor's requirements, Dutch international NGO (INGO) Cordaid (Caritas/Cordaid) decided to provide an integrated model of MHPSS in five administrative departments of Haiti; Department West (Delmas area of Port-au-Prince, Carrefour, Leogane, Petit Goave), Department Artibonite (Gonaives), Department North (Cap-Haitien), Department North-East (Fort Liberté) and Department South-East (Jacmel, Cayes Jacmel).

Strategy for providing integrated mental health/psychosocial support

Cordaid started providing MHPS support in Department West, one of the hardest hit by the earthquake, and with the aim of replicating the model to expand activities to other targeted departments with a high number of displaced earthquake affected population (One Response, 2010). The integrated MHPS support was provided in cooperation with local NGO partners, the Ministry of Public Health and Population (MPHP) and local health departments. Community level workers from local NGO[1] partners delivered community based MHPS interventions in the targeted areas, and identified cases for referral to PHC workers. Identification, recruitment and a series of short (three to five day) mental health trainings for community level workers were supplied by the Cordaid's mental health team, comprising general practitioners, psychologists and social workers, additionally supported by general practitioners and international and local psychiatrists as external consultants. At the same time, the programme aimed to initiate a process of integration of mental health into primary health care (PHC) by training PHC workers of local NGO partners and the establishment of a referral system between targeted communities and NGO and government health systems.

Methods

Methods of assessment of MHPS needs/services

A field based assessment in Department West was done in March and April 2010. Additional assessments were done from October to January 2011 in all other departments, before the start of implementation in these areas.

In all assessments, data collection methods included semi-structured interviews with key informants, focus group discussions with

beneficiaries and unstructured observation of patient encounters in primary health care. Quantitative data collection methods included a community survey and, in Department West only, a multiple choice mental health knowledge test. Sources of information included: representatives of local partner NGOs, representatives of INGOs involved in MHPSS in Haiti, MPHP, the Humanitarian Aid Department of the European Commission formerly known as the European Community Humanitarian Aid Office (ECHO), institutions teaching social work and psychology, local mental health professionals, general health professionals, representatives of communities and direct beneficiaries. The interviews began with the exploration of mental health needs and services, and continued with the focus on organisation in MHPS support and ideas on how to best deliver it. Information from beneficiaries, i.e. the earthquake-affected population, was collected during focus group discussions. In most of the cases, focus groups were held with members of one extended family. The topic guide for discussions included: questions related to different aspects of wellbeing of beneficiaries (emotional, economic, social, family, religious and cognitive); their need for MHPS support; and ideas on how to best deliver it. Interviews and discussions were stopped when no new information or themes emerged. Unstructured observation of patient encounters was held in primary health care and mobile clinics with the expatriate mental health advisor as an observer. The community survey was done during a half-a-day participatory workshop in the Delmas area, with a questionnaire on emotional, economic, social, family, religious and cognitive aspects of wellbeing. The mental health knowledge tests in Creole and French were given to five community level and five PHC workers, respectively, at the same workshop. Both tests were abbreviated versions of the tests previously used in the post tsunami mental health project in Sri Lanka (Budosan and Jones, 2009). The test for community level workers contained 10, and the test for PHC workers 12, questions on identification and treatment of stress, and common and severe mental disorders.

Methods of implementation

The role of community and PHC workers within the targeted Haitian communities and existing PHC system, respectively, and their expressed interest on implementing newly acquired mental health knowledge/skills in their everyday practices, were the two most important conditions for the selection of training participants. Presentations for trainings of community level and PHC workers were developed by the expatriate Mental Health Advisor in English, and then translated into Creole and French by Cordiad's mental health team, respectively (Table 1). Presentations for PHC workers were developed according to the *Mental Health Gap Action Programme Intervention Guide (mhGAP IG)* from the WHO (World Health Organization, 2010b).

Cordaid's Mental Health Advisor developed a manual for community level workers and one for PHC workers, translated into Creole and French, respectively. Training staff resources included one international and three local psychiatrists, three local general practitioners, four local psychologists and four local social workers. The theoretical mental health knowledge was measured with 20 item multiple-choice tests, before and after, the training intervention in both groups of trainees. Both tests were abbreviated versions of tests previously used in mental health projects in Sri Lanka, post tsunami (Budosan & Jones, 2009). However,

Table 1. Topics for training community level and primary health care workers

Topics for community level workers	Topics for PHC workers
Presentation of Cordaid's MHPS programme in Haiti	Presentation of Cordaid's MHPS programme in Haiti
Mental health/psychosocial support in disaster settings	General principles of care
Definition of mental health/psychosocial	Priority mental, neurological and substance abuse conditions
Stress/distress	Depression
Loss and grief	Self-harm
Coping/resilience	Psychosis
Communication skills	Stress/distress
Psychological first aid	Other significant emotional or medically unexplained complaints
Problem solving skills, anxiety management, Anger management	Alcohol use and alcohol use disorders
Family and peer support	Drug use and drug use disorders
Groups with special needs	Essential medicines for mental disorders
Psychological support	Family and peer support
Basic stress management	Effects of extreme stressors on children and adolescents
Basics of depressive and anxiety disorders	Developmental disorders
MHPS support within traditional healing and primary health care system	Behavioural disorders
Posttraumatic stress disorder	Psychosocial interventions
Basics of psychosis	Posttraumatic stress disorder
Helping the helper	Dementia
	Epilepsy
	Mental health/psychosocial support within traditional healing and primary health care system

these contained more questions on identification and treatment of stress, and common and severe mental disorders, than those used during the assessment stage. The satisfaction of participants with various aspects of training was measured on a 4-point Likert scale: 1) very much; 2) much; 3) very little; and 4) not at all. This scale was previously used in the mental health programme in Sri Lanka, post tsunami (Budosan et al., 2007). The aspects of the training that were evaluated were: 1) usefulness of training; 2) clarity of presentations; 3) interest of participants for the training; 4) capacity of training to empower participants to transfer received knowledge; 5) time allocated for questions; 6) treatment of participants during the training; and 7) appropriateness of training materials to the specific Haitian context.

Results

Results of the field-based assessment

In all the interviews, health professionals (PHC doctors and psychiatrists) and representatives of different organisations and communities mentioned the gap between mental health needs and the existing services in Haiti, especially after the earthquake. A majority of PHC doctors, and all psychiatrists, stated that there was an increase in mental health problems in their practices after the earthquake. In discussions, most of the beneficiaries mentioned they were suffering from a variety of mental health problems, such as loss of sleep, fear of another earthquake, lack of concentration, flashbacks, memories of the recent earthquake, and sadness expressed in terms of headache, non-specific body pain, feeling empty and/or heavy-headed. Most beneficiaries were the least satisfied with the economic and emotional aspects of their wellbeing. This result was in tune with the results from the community workshop in Delmas. In discussions, both mental health and psychosocial interventions were considered priorities by many beneficiaries. A majority of the beneficiaries mentioned lack of MHPS support in their local communities, and especially in the internally displaced persons camps. Most of PHC doctors expressed their interest in mental health training, and the process of integrating mental health care into primary health care. They mentioned that 20–30% of their patients had some mental health problems, but they lacked the knowledge/skills of how to assist them. The need for mental health training of PHC doctors was corroborated by observations of their practices, which showed that in majority of patient encounters they prescribed exclusively diazepam for all kinds of mental health problems (sleep problems, depression, anxiety, psychosomatic problems). The use of other psychiatric medications, and any psychotherapeutic techniques in primary health care, was practically nonexistent. Mid level PHC workers were generally not involved in providing mental health assistance, mostly because PHC doctors did not see any role for them in helping people with mental problems at the primary health care level. Most PHC doctors agreed that a workshop model was the best model to deliver mental health care training in Haiti. Finally, the results of the mental health knowledge tests confirmed a need for mental health care training, of both community level and PHC workers, as a necessary prerequisite to deliver good quality MHPS interventions. Mean total percentage of correct answers on the knowledge test for community level workers was 43%, and 22% for PHC workers. Most of the interviewed representatives, PHC doctors and psychiatrists, agreed that MHPS intervention should be delivered, both in the communities and within the existing health system. Furthermore, that mental health and psychosocial interventions should complement each other. Beneficiaries expressed their wish to have MHPS assistance in their communities, including internally displaced persons camps, but also to have better access to mental health care within the existing health system, if and when needed.

Results of the implementation (first seven months of the project)

After the series of basic mental health trainings, the knowledge of community level workers improved on average by 33.8% compared to the baseline figures (Table 2), and mental health knowledge of PHC workers by 29.7% compared to the baseline figures (Table 3).

On average, 100% of community level workers and 92% of primary health care

Table 2. Results of basic MHPS trainings for community level workers in all targeted departments in Haiti

Training location	Training dates	Pre test (percentage of correct answers)	Post test (percentage of correct answers)	Improvement (in percentage compared to baseline)
Martissant	11–14 January 2011	45	59	31
Petit Goave	25–28 January 2011	40	50	25
Gonaives	8–11 February 2011	39	56	43.6
Jacmel	22–25 February 2011	57.6	58.8	2.1
Cap Haitien	28 February – 4 March 2011	40.2	60.8	51.2
Forte Liberte	28 February – 4 March 2011	42.4	63.5	49.8

Table 3. Results of basic MHPS trainings for primary healthcare workers in all targeted Departments in Haiti

Training location	Training dates	Pre test (percentage of correct answers)	Post test (percentage of correct answers)	Improvement (in percentage compared to baseline)
Martissant	1–4 February 2011	29	48	65.5
Gonaives	28 March – 1 April 2011	37	49	32.4
Jacmel	28 March – 1 April 2011	44.4	54.8	23.4
Cap Haitien	28 March – 1 April 2011	45	53	17.8
Petit Goave	4–8 April 2011	40	43.8	9.5

workers, who participated in the trainings, considered them to be very useful.

Discussion

In the first seven months of its implementation, Cordaid's MHPS trainings achieved satisfactory results in regard to the improvement of MHPS knowledge of both community level and PHC workers. The average improvement in knowledge of community level workers was better than, for example, occurred in a similar mental health training in Sri Lanka, post tsunami (Budosan & Jones, 2009), but lower than in the training of PHC workers in Grenada (Kutcher, Chehil, & Roberts, 2005). Lecomte (2010b) stated that community level workers, if provided with adequate training, could assist with many MHPS problems in Haiti (for example: anxiety, depression, distress, violence, problems with alcohol and drugs). Lecomte and Raphael (2010) emphasised a need for training of different providers of MHPS care in Haiti, and Raphael (2010) supported the integration of mental health into PHC as a way to reconstruct Haitian mental health care services. According to the World Health Organization (2008), primary health care for mental disorders is affordable, cost effective and generates good outcomes. In their articles on mental health in Haiti, local health and mental health professionals advocate for a strategy to provide integrated MHPS support, through integration of informal community level and formal health level sector (Caron, 2010a; Caron, 2010b; Lecomte and Raphael, 2010; Lecomte, 2010b). According to the *Guidance Note for Mental Health & Psychosocial Support in Haiti post earthquake*, well integrated mental health and psychosocial support that builds on existing capacities and cultural norms reaches more people, and is more likely to be sustained once humanitarian aid engagement ceases. Psychological and social interventions after a disaster should be combined with the development of mental health services within PHC (van Ommeren, Saxena & Saraceno, 2005).

Main constraints and limitations

The described programme has not been able to significantly change the actual clinical practices of PHC workers. This also negatively affected the planned development of a referral system in targeted departments. Although community level workers were able to identify some cases of more severe mental health problems in need of referral, it seems that PHC workers were not motivated enough, either professionally or financially, to offer them assistance. According to the World Health Organization (2008), sustainable changes in mental health practices of PHC workers can be achieved only as a result of a several efforts combined, which include: mental health training, political will of the government, formulation of mental health policy promoting the integration of mental health into PHC, PHC workers and mental health care professionals motivated to develop community mental health services, and supervision of non-specialised health staff by mental health professionals (World Health Organization, 2008). The World Health Organization in Haiti is currently working with key local and international mental health players in Haiti to develop a mental health policy for the country. Their mental health strategy is to appoint multi-disciplinary teams of mental health professionals to supervise implementation of mental health policy in all Haitian departments. Still, according to Cordaid's experience so far, it might be a difficult task to motivate Haitian PHC workers to integrate mental health care into their practices.

A second problem the programme faced was a limited level of active cooperation from formal governmental health authorities. In spite of numerous efforts to raise the interest of government representatives for its MHPS program, Cordaid did not receive adequate responses, either from the representatives of MPHP, nor from the representatives of local health departments. This makes it very difficult to institutionalise its strategy within the government sector, and coordinate efforts with the government. Many Haitian health and mental health professionals see the limited capacity of the Haitian government as one of the major obstacles for development of a mental health strategy in Haiti (Caron, 2010b; Raphael, 2010; Henrys, 2010; Lecomte, 2010b). Mental health has been recognised by the World Health Organization as the second most important priority for Haiti after the earthquake, but it has still not been considered as a priority by the Haitian government (Henrys, 2010). However, lack of an administrative unit for Mental Health within MPHP in charge of planning, organisation and coordination of mental health services, hindered these efforts so far, and is considered as a major constraint for developing a mental health care strategy in Haiti (Bijoux, 2010). The recent appointment of a focal person for mental health in MPHP will hopefully improve cooperation and coordination of MHPS activities among INGOs, local NGO partners and the Haitian government.

During the initial implementation stage, Cordaid also encountered some problems with its local NGO partners who seemed to be oriented more towards their own needs, i.e. development of their own human and material resources, than in the delivery of good quality MHPS intervention to the earthquake affected population. Douyon (2010) mentions an individualistic attitude of Haitians as one of the reasons why, in spite of massive international assistance and the surge of international experts, there was no real progress in Haiti in the past. However, this is not in line with traditional Haitian voodoo values of sharing, community spirit and solidarity (Douyon, 2010). In the absence of a National Psychiatric Association and exchange of psychiatric practices, Bijoux (2010) also mentioned a prevailing individualism impacting the provision of mental health care services in Haiti.

Similarities and differences with other strategies of MHPS support in disaster settings

Different strategies of MHPS support have been applied in complex emergencies and after disasters, worldwide. For example, in Sri Lanka, post tsunami, the World Health Organization recruited, trained and appointed community level workers to work with affected communities (Mahoney, Chandra & Harischandra, 2006). This initiative was complemented with mental health training of PHC workers by an INGO in three districts (Budosan et al., 2007; Budosan and Jones, 2009). Somasundram (2006) stated that the training of community level workers in basic mental health, and developing a referral system in PHC was the most cost effective strategy of providing MHPS support in Sri Lanka.

The training programme of health professionals in Grenada, after hurricane Ivan, was an integrated, community based, mental health response delivered through an existing mental health care system, and was therefore substantially different from most other post disaster mental health activities delivered in Caribbean (Kutcher, Chehil & Roberts, 2005). According to the same source, most mental health interventions following disasters in the Caribbean have been vertically delivered, and are largely ineffective and costly psychosocial programmes.

In Haiti, there were also many vertical MHPS interventions delivered by different local and international MHPS players, and with no clear integration of psychosocial and mental health programming (Mental Health & Psychosocial Support Network, 2010). Cordaid's strategy tries to complement MHPS interventions within communities with mental health interventions within the health care system. According to Lecomte and Raphael (2010), basic MHPS services, although scarce, exist in Haiti, but they are not properly integrated. Since Haiti is prone to natural disasters, such as draught, floods and hurricanes, and international and national assistance is frequently impermanent (World Health Organization, 2010a), developing integrated system of MHPS support in Haiti can also serve as a preparation for new emergencies (WHO, 2003).

Lessons learnt and the way forward

According to our experience in Haiti so far, both Haitian NGOs and individuals tend to be very much concerned about their rights; they like to negotiate and renegotiate their contractual agreements. This can sometimes make it difficult to reach an agreement, particularly with local NGO partners who are solicited by various international organisations. At the same time, the output of some local organisations may not meet their contractual obligations if their activities are not properly and frequently monitored. Agreements with local NGO partners have to be done on a case-by-case basis, because there are no national rules and regulations.

Recently, Cordaid has become a member of mental health group headed by WHO Haiti. This group is in charge of mapping mental health care services in the country, and developing mental health care policy and strategy for Haiti. Cordaid has been doing an extensive mental health care programme in Haiti, covering five out of ten administrative departments, it is recommended by the Mental Health Advisor that Cordaid shares the results and challenges of its programme with the other members of mental health group. A future evaluation of Cordaid's community-based part of the MHPS intervention implemented by trained community level workers in targeted Haitian communities is needed, to see which MHPS techniques were culturally appropriate and effective for mental health problems among Haitians.

Acknowledgments

We are grateful to Angela Jansen, Student of International Development Studies of the University of Amsterdam for her valuable comments regarding the manuscript. Thanks to following donors for providing funding for mental health/psychosocial programming in Haiti: The European Commission's Humanitarian Aid department (ECHO), Cordaid under grant No. 104299, and Cordaid and Trocaire under grant No. 103063.

References

Benjamin, R. (2008). *Violence conjugale en Haïti : Un défi à relever.* Paper presented at symposium 'Towards a partnership in mental health.' Québec, April 24th 2008. Online symposium summary. Available at: www.haitisantementale.ca.

Bijoux, L. (2010). Evolution des conceptions et de l'intervention en santé mentale en Haïti. *Revue haïtienne de la santé mentale*, No. 1. Available at: http://www.haitisantementale.ca/pdf/conception.pdf.

Budosan, B., Jones, L., Wickramasinghe, W.A.L., Farook, A.L., Edirisooriya, V., Abeywardena, G. & Nowfel, M. J. (2007). After the Wave: A pilot project to develop mental health services in Ampara district, Sri Lanka, post-tsunami.

Journal of Humanitarian Assistance. Published online September 16 2008, Available at: http://www.jha.ac.

Budosan, B. & Jones, L. (2009). Evaluation of effectiveness of mental health training program for primary health care staff in Hambantota district, Sri Lanka, post-tsunami. *Journal of Humanitarian Assistance*, published 1 May 2009. Available at: http://jha.ac.

Caron, J. (2010a). Quelques réflexions sur la situation actuelle d'Haïti, la prévention des maladies mentales et la promotion de la santé mentale de sa population. *Revue haïtienne de la santé mentale*, No. 2. Available at: http://www.haitisantementale.ca/revue_n2/n2art6.pdf.

Caron, J. (2010b). La santé mentale dans une perspective de santé publique: quelques réflexions sur la santé mentale en Haïti. *Revue haïtienne de la santé mentale*, No. 2. Available at:http://www.haitisantementale.ca/revue_n2/n2art5.pdf.

Clouin, L. (2009). *Pratique de soin et santé mentale en Haïti: Rapport d'évaluation*. Available at: http://oneresponse.info/Disasters/Haiti/MHPSS/Pages/MHPSS.aspx.

Douyon, E. (2010). Société haïtienne: attitudes et développement. *Revue haïtienne de la santé mentale*, No. 2 Available at: http://www.haitisantementale.ca/revue_n2/n2art4.pdf.

Henrys, D. (2010). Réflexions sur une politique de santé mentale en Haiti. *Revue haitienne de la santé mentale*, No. 2. Available at: http://www.haitisantementale.ca/revue_n2/n2art13.pdf.

Inter-Agency Standing Committee (2007). *IASC Guidelines on mental health and psychosocial support in emergency settings*. Geneva: IASC. Available online: http://icn.ch/IASC_MHPSS_guidelines.pdf.

Kutcher, S., Chehil, S. & Roberts, T. (2005). An integrated program to train local health care providers to meet post-disaster mental health needs. *Revista Panamericana de Salud Pública/Pan American Journal of Public Health, 18 (4/5)*. Available at: http://journal.paho.org/uploads/1137002807.pdf.

Lecomte, Y. (2010a). Pour un réseau de soutien communautaire en santé mentale. *Revue haïtienne de la santé mentale*, No. 2. Available at: http://www.haitisantementale.ca/revue_n2/n2artl2.pdf.

Lecomte, Y. (2010b). La santé mentale en Haïti: le nouvel eldorado? *Revue haïtienne de la santé mentale 2*. Available at: http://www.haitisantementale.ca/revue_n2/n2art1.pdf.

Lecomte, Y. & Raphael, F. (2010). Editorial: Les modèles d'intervention dans une Politique de santé mentale en Haiti. *Revue haïtienne de la santé mentale 2*. Available at: http://www.haitisantementale.ca/revue_n2/n2art2.pdf.

Mahoney, J., Chandra, V., Harischandra, G., Mendis, J. & Suvendraan, T. (2006) Responding to the mental health and psychosocial needs of the people of Sri Lanka in disasters. *International Review of Psychiatry, 18 (6)*, 593-597 (5).

Mental Health and Psychosocial Support Network (2010). *Haiti 4Ws Matrix MHPSS* 13 March, 2010. Available at: http://www.psychosocialnetwork.net/regions/153/upload/haiti_4ws_matrix/view_resource.

One Response (2010). *Note de synthèse. Mouvement de populations hors Port-au-Prince et zones affectées depuis le séisme: Impact sur les départements d'accueil.*

Available at: http://oneresponse.info/Disasters/Haiti/statisticsreports/Pages/default.aspx.

Raphael, F. (2010). Reflexions sur la sante mentale dans une Nouvelle Haiti. *Revue Haitienne de la sante mentale*, Numero 1.Available at: http://www.haitisantementale.ca/pdf/reflexion.pdf.

Schininá, G., Aboul Hosn, M., Ataya, A., Dieuveut, K. & Salem, M. (2010). Psychosocial response to the Haiti earthquake: the experiences of the International Organization for Migration. *Intervention*, *8*, 158-164.

Somasundram, D. (2006). Disaster mental health in Sri Lanka. In *Advances in Disaster Mental Health and Psychological Support.* Available at: http://hpod.pmhclients.com/pdf/advances-in-disaster-mental-health.pdf.

Van Ommeren, M., Saxena, S. & Saraceno, B. (2005). Mental and social health during and after acute emergencies: emerging consensus? *Bulletin of the World Health Organization*, *83*, 71-75.

World Health Organization (2003). *Mental health in emergencies*. Geneva:World Health Organization.

World Health Organization (2005). *Mental Health Atlas*. Geneva: World Health Organization. Available at: http://www.who.int/globalatlas/predefinedReports/default.asp.

World Health Organization (2008). *Integrating mental health into primary care: A global perspective*. Geneva: World Health Organization.

World Health Organization (2010a). *Culture and Mental Health in Haiti: A literature Review.* Geneva,World Health Organization. Available at: http://www.who.int/mental_health/emergencies/culture_mental_health_haiti_eng.pdf.

World Health Organization (2010b). *mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings*. Available at: www.who.int/mental_health/mhgap.

[1] The partner organisations included : Initiative pour le developpement des jeunes (Idejen), International Child Care (ICC), Service Oecumenique d'Entraide (SOE), Solidarite Fanm Ayisyen (Sofa), Centre de Promotion des Femmes Ouvrières (CPFO) and Caritas Haiti.

Dr Boris Budosan, MSc., M.P.H., psychiatrist, is a Mental Health Advisor for Cordaid, Haiti.
email: bbudosan@yahoo.com.
Dr Rachel Frederique Bruno, M.D. is a Project Manager for Cordaid, Haiti.
email: rachel.bruno@cordaid.net.
Correspondence to Dr. Boris Budosan, MSc. M.P.H., Consultant Psychiatrist, Mental Health Advisor for Cordaid, The Netherlands, EU,Vocarsko Naselje 22, 10000 Zagreb, Croatia. Tel: +385 1 46 16 267; fax: +385 1 23 20 298; email: bbudosan@yahoo.com