LAWYERS WITHOUT BORDERS
AVOCATS SANS FRONTIERES
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Canada

MEETING THE NEEDS OF CHOLERA VICTIMS IN HAITI

FEASIBILITY OF AN INDIVIDUAL ASSISTANCE APPROACH FOR PEOPLE MOST AFFECTED BY THE DISEASE

Project: "Access to Justice and Fight Against Impunity in Haiti"

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Lawyers without Borders Canada (LWBC) is a non-governmental international cooperation organization whose mission is to support the defense and exercise of human rights by strengthening access to justice and legal representation for people in situations of vulnerability.

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PREFACE

In October 2019, the UN will conclude 25 years of peacekeeping in Haiti. Since my deployment to this country in 1993, to lead the legal department of the then UN/OAS mission, I have participated in UN peace missions in Rwanda, Kosovo and Darfur, among others. In that time, I witnessed important UN peacekeeping successes, including crucial progress in building the Haitian National Police and creating the first magistrates' school in Haitian history. But the UN peacekeeping record in Haiti also has some grave failures, most significantly the introduction of cholera by UN peacekeepers in 2010.

The introduction of cholera to Haiti by the UN resulted in indescribable suffering and had, and continues to have, devastating effects on the country. The UN's subsequent refusal to admit any liability has compounded the harm, severely tarnishing the United Nations' image in Haiti, and the credibility of UN peacekeeping globally. It is a betrayal of our common oath to protect the most vulnerable and promote human rights for all. In 2016, when the Secretary General finally apologized for the UN's role in the epidemic, he rightly stressed that the "tragedy has cast a shadow upon the relationship between the UN and the people of Haiti. It is a blemish on the reputation of UN peacekeeping and the organization worldwide."

As the UN transitions to a Special Political Mission in Haiti in 2019, both the legacy of UN peacekeeping in Haiti and the credibility of the United Nations' ongoing presence in the country will be in no small part determined by the Organization's response to the cholera crisis, and to the victims whose lives have been shattered by the epidemic. If the UN truly stands for the rule of law, then it must hold itself to the same standards of accountability, transparency and respect for human rights that it demands of others.

This report by Lawyers without Borders Canada, in collaboration with the Interuniversity Institute for Research and Development, will play a critical role in helping the UN craft a fair and successful response in Haiti. It is the first study to outline the impacts of cholera on affected families and communities and to set out the victims' views and priorities regarding the UN response, including the crucial question of whether assistance should take the form of community projects or direct payments to victims and survivors. The report also presents a detailed feasibility analysis of what an individual assistance package for cholera victims might look like, concluding that a mix of individual payments and community projects is both possible and desirable to respond to the physical and economic harms suffered by the victims, while simultaneously honoring their dignity.

The United Nations will find in this study a realistic and feasible road map to help it assume its responsibilities and provide fair redress to civilians killed or injured in the course of its peacekeeping missions. More specifically, it gives decision-makers the necessary tools to follow through on the promise the UN made in 2016, in its "*New Approach to Cholera in Haiti*", to assist cholera victims and ease their suffering. For the past years, the UN has been making decisions on the implementation of this "*New Approach*" with no robust, transparent information on victims' needs and the feasibility of direct payments. This study fills this gap, by providing crucial policy guidance to those who want to see the UN come out on the right side of history in Haiti.

A satisfactory response to cholera is critical to the UN's future in Haiti, but not only in Haiti. The UN's actions will send a message worldwide about its willingness – or lack thereof – to accept responsibility for its actions, especially when these result in harm to the very people the UN has promised to protect. At a time when the principles and values of the United Nations are increasingly under attack, the UN should seize this opportunity to show that it has adopted a model for practical, meaningful accountability in its operations. It is no exaggeration to say that faith in the promise of UN peacekeeping lies in the balance.

Bill O'Neill
Consultant indépendant

PROLOGUE

Since cholera was brought to Haiti in October 2010, at least 9,800 persons have died and over 820,000 Haitians have contracted this disease, which had been non-existent in the country until then. The loss of these thousands of human lives and the extensive suffering caused by the epidemic are a real tragedy, from which Haitian society is still struggling to recover to this day. Those who have survived the disease or who have lost loved ones to cholera can only overcome this ordeal with appropriate assistance that respects their dignity, their needs and their rights.

This study shows that the material assistance and support package for victims, as described in the UN document *A New Approach to Cholera in Haiti*, can be implemented using an approach that focuses on victims' rights, needs and priorities. Such an approach is in line with prevailing practice in similar contexts, as well as with international human rights standards developed by the United Nations.

The UN is not only bound to enforce and implement these international standards, it must itself respect and apply them. It must ensure that its actions are guided at all times by the principles and goals set out in its founding charter. That is why UN Secretary-General Ban Ki-Moon said in 2016 that the cholera epidemic is a test of the UN's commitment to the most vulnerable: "At a time when so many of UN values and principles are under threat, the Haiti cholera challenge represents an important test. It is a test of our commitment to the most vulnerable. It is a test of our long-standing relationship with the Haitian people. It is a test of our ability to demonstrate compassion while preserving our ability to do good in many other places around the world. It is a test of our collective responsibility for the crucial endeavour of peacekeeping."

Since 2016, the United Nations has taken a number of steps to acknowledge and respond to the victims' suffering. The Secretary-General apologized to the Haitian people for the harm caused by cholera and affirmed that the United Nations bore moral responsibility to the victims. The UN has created a voluntary trust fund to respond to the cholera crisis, in addition to presenting its *New Approach to Cholera in Haiti*. Through the *New Approach*, the UN commits to placing victims at the centre of the process and to evaluating the feasibility of an individual approach to assistance for cholera victims. These efforts demonstrate the UN's commitment to meeting the needs of communities most affected by cholera. Several factors will determine whether this process is successful in addressing the suffering of the victims, including the adoption of symbolic measures to reflect the UN's regret.

Furthermore, additional assistance to complement the community initiatives is required to provide specific relief for the plight of the most severely affected victims. In fact, the human tragedies caused by the cholera epidemic are unfortunately perpetuated over time. These tragedies are those of the children whose future opportunities have been severely curtailed by the loss of a parent, the women who have become single parents following the death of their spouse, the individuals who continue to suffer from physical or psychological distress and those whose access to health care is limited.

Righting the wrongs caused by cholera in Haiti entails significant challenges and risks. It means setting up an inclusive, fair and rigorous process to respond to the sometimes different needs of individuals and communities, identifying victims where documentation is limited and systematic medical diagnosis is absent, mitigating the risk of conflict within families and communities, convincing Member States to contribute financially to the reparations program, optimizing limited financial and administrative resources.

Because there has been little to no analysis of these themes, Lawyers without Borders Canada (LWBC), in collaboration with the Interuniversity Institute for Research and Development (INURED) and with the contribution of lawyers at the Institute for Justice & Democracy in Haiti (IJDH), prepared this feasibility study of an individual approach to assistance for victims of the cholera epidemic. In light of the results of this study, we find that it is possible to set up an individual assistance component for the most severely affected victims of the Haiti epidemic, while taking into account the associated practical challenges. Such a component should be introduced as a complement to the community initiatives supported by the UN in the communities most affected.

Since the second component of the UN's *New Approach* aims to acknowledge the suffering endured by the Haitian people and effectively combat the harmful effects of cholera on individuals, families and communities, the voices of the victims must be central to its implementation. That is why a victim consultation process was conducted by INURED in a number of communities across the country that were affected by the disease. The results of this survey show that the victims and the members of the communities hardest hit by cholera would prefer a mixed approach that combines individual assistance, in particular for those most affected by the cholera epidemic, with collective measures.

Having made that determination, LWBC and its partners analyzed the feasibility of an individual component for these categories of victims, based on semi-directed discussions conducted in three (3) communes of the country and in Port-au-Prince, and on interviews with specialists who have contributed to the design or implementation of similar programs in Haiti and elsewhere.

This study forms part of the LWBC's project *Accès à la justice et lutte contre l'impunité en Haïti* (Access to Justice and Fight Against Impunity in Haiti, AJULIH), which aims to strengthen the protection of human rights and contribute to improving access to justice for people in situations of vulnerability. Its intention is to offer the United Nations, the Haitian State, potential financial contributors, Haitian civil society and any other involved or interested parties the information and analyses at our disposal with respect to victims' expectations and the feasibility of an individual component that would complement the collective measures being implemented by the UN. The hope is that it can be a tool to help make informed decisions based on complete and reliable information.

We hope that it will allow the United Nations, Member States, the Haitian State as well as financial contributors to consider the full range of possible measures to respond to the needs and fundamental rights of the victims of cholera.

Pascal Paradis
Executive Director, LWBC

LIST OF ABBREVIATIONS

ASEC	Assemblée des sections communales (Assembly of communal sections)
ASOVIK	Association des victimes du choléra (Association of cholera victims)
CAL	Centre de santé avec lits (health centre with beds)
CASEC	Conseil d'administration des sections communales (Board of Directors of communal sections)
CSL	Centre de santé sans lits (health centre without beds)
CTC	Cholera treatment centre
CTU	Cholera treatment unit
CU	Centralized Unit
DERL	Direction d'épidemiologie, de laboratoire et de recherche (Epidemiology, Laboratory and Research Directorate)
EMIRA	Équipe mobile d'intervention rapide (Mobile rapid response team)
FONKOZE	Fondasyon Kole Zepòl
GHESKIO	Groupe haïtien d'étude du sarcome de kaposi et des infections opportunistes
HCR	Hôpital Communautaire de référence (community referral hospital)
HUEH	Hôpital de l'Université d'État d'Haïti (Haitian State University Hospital)
IJDH	Institute for Justice & Democracy in Haiti
INURED	Institut Interuniversitaire de recherche et de développement (Interuniversity Institute for Research and Development)
MESI	Monitoring, Evaluation and Surveillance Interface
MINUSTAH	United Nations Stabilization Mission in Haiti

MOMVIK	Mouvement des organisations des personnes victimes du choléra (Movement of cholera victims organizations)
MSF	Doctors Without Borders
MSPP	Ministère de la Santé Publique et de la Population (Ministry of Public Health and Population)
OVICH	Organisation des victimes du choléra en Haïti (Organization of cholera victims in Haiti)
PAHO	Pan American Health Organization
PSV	Populations in situations of vulnerability
RD	Regional Directorate
RO	Registering Officer
SG	Secretary-General
SOFA	Solidarité Fanm Ayisyèn
SSPE	Structure de santé de premier echelon (level one health care facility)
UN	United Nations Organization
UNICEF	United Nations Children's Fund
WHO	World Health Organization
ZANTRAY	Zanfan Tradisyon Ayisyen

EXECUTIVE SUMMARY

Lawyers without Borders Canada and its partners present this study, which analyzes the feasibility of including an individual approach as part of a package of material assistance and support for cholera victims in Haiti.

In this study, LWBC focuses on the needs, expectations and priorities expressed by the victims, and puts forward practical means of identifying them and verifying their information as well as a simplified, accessible model for dealing with requests from victims in an efficient and fair manner. A package of material assistance and support that combines a collective approach with specific support for the victims most affected by cholera would take into consideration the victims' expectations, as expressed in the course of this study, compared experiences, international human rights standards and the commitments of the United Nations (UN) under its *New Approach to Cholera in Haiti*.

Following an analysis of the benefits, risks and practical challenges of such an approach, LWBC makes recommendations for an appropriate response to the plight and needs of victims. These proposals are directed at the actors responsible for implementing the UN's New Approach, the UN Member States, potential financial contributors and the Haitian State, and are likely to be of interest to representatives of civil society organizations, cholera victims and the Haitian public in general. We hope that this tool will contribute to the development and adaptation of mechanisms that can adequately take into account the particular needs of victims as well as the gender-specific impact of the disease.

This study is part of the project *Accès à la justice et lutte contre l'impunité en Haïti* (Access to Justice and Fight Against Impunity in Haiti, AJULIH), a project implemented by LWBC. The study was conducted in collaboration with the Interuniversity Institute for Research and Development (INURED) and benefited from contributions by lawyers at the Institute for Justice & Democracy in Haiti (IJDH).

BACKGROUND

In 2004, the UN Security Council (SC) passed Resolution 1542 establishing the United Nations Stabilization Mission in Haiti (MINUSTAH). In October 2010, a contingent of Nepalese Blue Helmets was deployed to Haiti, in the Meille zone in the district of Mirebalais. At that time, cholera was endemic to Nepal. On October 21, 2010, the Haitian government confirmed the presence of the cholera virus, which was spreading at an alarming speed. On November 19, 2010, the Ministry of Public Health and Population (MSPP) declared that the epidemic had spread to all departments in the country.

At this time, although its incidence has decreased significantly, the virus remains present in Haiti and continues to claim victims. According to the MSPP's official records, 4,000 new cases of cholera were reported in 2018, including nearly 50 deaths. As of January 2019, the total number of victims of the epidemic in Haiti since its outbreak stood at almost 820,000, including more than 9,800 deaths.

Scientific studies on the source of the disease came to the same conclusion: the Nepalese peacekeepers introduced cholera into Haiti by discharging waste water from their camp into the tributaries of the Artibonite River. On August 19, 2016, the UN acknowledged its moral responsibility for the epidemic, and on December 1 of the same year, made a formal apology to the Haitian people and introduced its *New Approach to Cholera in Haiti*.

The *New Approach* aims to "intensify efforts to eliminate cholera from Haiti and provide assistance to those most directly affected," and proposes a two-pronged action plan. The first component comprises two aspects: 1) the eradication of cholera in Haiti and access to health care and 2) access to water, sanitation and health care in the longer term. The second component of the *New Approach* aims to provide material and financial assistance to the victims hardest hit by the epidemic, their families and their communities. It also includes two possible areas of focus: a community-based approach and an individual approach.

When it was presented, the *New Approach* included the possibility of providing direct financial assistance in the form of payments to the families of deceased cholera victims in addition to the establishment of community-based assistance programs. In this sense, the New Approach recognized the need to conduct a more in-depth examination of the feasibility of such measures "in light of the major challenges, risks and obstacles" they raise, and committed to consulting the victims with a view to developing the assistance package.

However, so far, there has been no public feasibility study of an individual approach and the UN appears to be gradually moving towards a strictly community-based approach. The victims most affected by cholera have not participated in a consultation process on the possibility of including an individual component in the package of material assistance and support, and on their needs, expectations and priorities as to how best to address the suffering they have personally experienced.

RESULTS OF CONSULTATIONS WITH VICTIMS

a) Impact of cholera in Haiti

The discussion groups and individual interviews conducted by INURED reveal that the disease has had physical, psychological and economic consequences for victims and that the impact has been even greater on children.

The study highlights the significant economic impacts suffered by victims and their families and their centrality to the perceived suffering of victims, many of whom have lost their family breadwinner or are unable to recover financially from significant debt. The study also highlights how cholera has had a disproportionate impact on some groups, thus contributing to the further marginalization of certain populations in situations of vulnerability (PSVs). This is particularly the case for families in a precarious financial situation, children, and women and girls.

b) The hardest-hit victims of cholera

Recognizing that cholera has not affected all individuals in the same way, the victims believe that the assistance offered should reflect the different levels of suffering. According to them, the "hardest-hit victims" are the family members of the deceased, particularly women, children and individuals who have lost the family breadwinner. Although some victims consider that cholera survivors are the "second hardest-hit victims", they believe nonetheless that assistance for survivors should be less than that for the family members of individuals who lost their lives to cholera.

c) Individual approach: benefits and risks

Thus, the victims emphasized their general preference for a mixed approach that would include both individual and community components. In addition to meeting human rights standards and the standards applicable in other similar situations that require large-scale assistance programs, an individual approach would, in the victims' opinion, take into account the specific and personal suffering of those who have been and continue to be disproportionately affected by the cholera epidemic, the economic impact as a central element of their suffering and the existing disparities between the different categories of victims.

They also expressed a specific preference for assistance implemented through unconditional cash transfers. The study shows that this type of assistance has multiple benefits for the beneficiaries and for society at large: meeting the specific needs of the beneficiaries and providing greater access to essential goods and services, economic stabilization and financial autonomy in the longer term, reducing social inequalities and the poverty level and improving the general living conditions of the population. When implemented in a complementary manner, cash transfers make it possible to overcome certain weaknesses in community programs.

Aware of the difficulties related to victim identification and access to official documents, the victims consulted stressed the importance of taking into account the risks of under-inclusion and revictimization. They also highlighted the risks of fraudulent claims and corruption.

The victims also acknowledged that introducing an individual approach may give rise to family and community conflicts. The victims believe that the main risks of family conflicts would lie in the determination of filiation and the equitable distribution of assistance among family members. For this reason, the victims would prefer the assistance to be disbursed directly to all members of the immediate family, while recognizing the practical and administrative difficulties associated with such an approach. However, if they were asked to choose a family representative, they would recommend that the funds be distributed through the family breadwinner or the surviving spouse.

In this sense, the victims argue that the feasibility of implementing this individual component would depend primarily on the ability of the United Nations to establish a rigorous and inclusive system of beneficiary identification and assistance distribution, thus mitigating the main risks of over-inclusion, under-inclusion and community and family conflicts that may arise.

d) The community approach: benefits and risks

According to the victims, any recommended package of material assistance should necessarily include a collective component, since it would be necessary to adequately take into account the profound consequences of cholera on Haitian communities and society in general. Collective approaches can reach a significant number of victims while being implemented through relatively simple and light measures. Implemented in conjunction with an individual component, the community approach could serve as a risk mitigation mechanism, particularly with respect to community and family conflicts.

However, the victims also pointed out the disadvantages of the community approach, especially if it is not implemented in conjunction with an individual component. They feared that a community approach would have limited and short-lived effects, mentioned the high risk of corruption and poor management and expressed little confidence in local institutions and actors.

The victims believe that community programs would not be enough to satisfy their needs, priorities and expectations or to specifically reach those persons considered to be the most severely affected. According to them, community programs fail to recognize the private and personal nature of their suffering and do not take into consideration the specific assistance they need. The victims believe that a collective approach implemented in isolation is likely to generate resentment among the most severely affected victims and significant family and community conflicts, as well as contribute to the exacerbation of existing social inequalities.

In short, they see the community and individual approaches as equally relevant and complementary. When implemented jointly, both approaches would allow for better management of their needs and allow each approach to balance the risks associated with the other.

FEASIBILITY OF AN INDIVIDUAL APPROACH

The feasibility of an individual approach is based on several fundamental elements, including the ability to: 1) adequately assess the parameters by which a person can be considered to have contracted or died of cholera, 2) officially identify these persons from the limited information available, and verify their information, 3) develop and implement an accessible, affordable and relatively reliable mechanism to decide effectively and fairly on possible claims, and 4) design a mechanism that includes strategies to mitigate the risks of community and family conflict and the risks of over-inclusion and under-inclusion of victims. In this regard, experiences with similar programs set up in other contexts provide interesting models and valuable lessons for the possible design of a mechanism adapted to the Haitian case.

In accordance with the practices observed in similar situations where resources are limited, the victims identified the need to give priority to the "hardest-hit" victims as beneficiaries of this more direct material assistance. They specifically identified as priority beneficiaries the immediate family members of individuals who died of cholera, with particular attention to women, children, youths and family members who suffered significant economic harm as a result of the loss of a breadwinner. Some of them also identified cholera survivors as a second priority group, particularly those who continue to suffer significant sequelae, although they acknowledge that this second category of victims should receive less assistance.

a) Identification of victims

Considering the evolution of the disease at the national level, this study points out that, given the incidence of the disease during the peak epidemiological period (between 2010 and 2013, and particularly from 2010 to 2011) and the information gaps for this period, anyone who showed clinical signs of cholera (and therefore met the official definition of a "suspected case" according to the MSPP) could be presumed to be a victim of the disease according to the balance of probabilities standard. The incidence of the disease having gradually begun to decrease by 2014, the probability that a patient with signs of the disease actually had cholera also began to decrease in proportion to this epidemiological evolution. The significant reduction in the number of cholera cases from 2017 on led the authorities to institutionalize new and more rigid criteria for determining a "suspected case".

Thus, the study suggests that the medical and practical considerations underlying the official definitions of a suspected case of cholera offer relevant indications for deciding on victims' applications and determining their status.

With respect to deaths, the study argues that any person 5 years of age or older who died approximately one week after admission for a suspected case of cholera or the reporting of clinical signs of the disease should be considered a cholera-related death. For children under 5 years of age, the case is more complex, as deaths associated with other diarrhoeal diseases are more frequent in this age group. Relative probabilities can be assessed based on whether or not the child was in contact with a suspected or confirmed case of cholera or whether there was a confirmed outbreak in that locality. The fact whether a rotavirus vaccination campaign was carried out in the child's area of residence could also indicate a high probability of cholera infection.

b) Victim identification system

This study examines how it might be possible to develop a system to identify victims and verify their information. The most important formal information source that might be mobilized would come from cholera patient care facilities, which kept records of the names and information of victims who were admitted, and notified the state of cholera-related deaths, as required by Haitian law. In this sense, the most promising information would be available at the local level - directly from the Cholera Treatment Centres (CTCs) and the various pre-existing facilities of the Haitian health system - as well as at the regional level, from the departmental health departments.

There are certain limitations to the data these sources may have. The data is likely to be uneven and incomplete, particularly in the early years of the epidemic, when the formal system was overwhelmed. In addition, although initial investigations confirm that these facilities did comply with the requirements of Haitian law, differences are to be expected in the extent and quality of the information available and the storage methods. Some victims may have provided a false identity upon admission in order to avoid stigmatization, although this risk would concern a limited number of victims.

These limitations notwithstanding, the information held by these cholera treatment facilities is promising and could be compiled in a consolidated database and used as a primary source to identify victims and verify their information.

Nevertheless, it will be necessary to complete the existing formal data with information held by other identification and verification mechanisms, notably community structures and informal information networks. This is particularly true for non-institutional victims. Based on the various field interviews conducted as part of this study, numerous key community actors appear to have played a role at different levels in the management of cholera in Haiti and would therefore have relevant information to offer this identification and verification exercise.

The study reports on the existence of organized community structures based on large and complex multilateral information exchange networks, which are believed to hold information essential to the implementation of a victim identification process. These networks are thought to be particularly well established in the case of the spiritual authorities (Christian and Vodou), some of which have even set up specific structures with the help of their members to monitor and collect data on cholera-related illness and death in their area. As such, these community actors and their respective information networks could potentially play a fundamental role in collecting, consolidating and verifying data on these victims at different levels of the country's administrative and community organization: hamlets, towns, communal sections or communes, particularly with respect to non-institutional victims.

c) Proposal of a model for deciding claims

The study proposes avenues for the development and effective implementation of a model for deciding victims' claims. These proposals relate to: 1) the determination of beneficiaries; 2) the applicable standard of proof and the types of admissible evidence; 3) the specific steps in a possible process for filing and deciding claims; 4) the determination of the amounts of assistance and methods of disbursement.

Two options are suggested for the determination of beneficiaries: 1) a procedure that allows claims submitted both by relatives of deceased persons and surviving victims (more inclusive and fair, but also more costly and complex); 2) a mechanism focusing specifically on the relatives of deceased individuals, but providing adequate funding for the specific needs, priorities and expectations of survivors via the response's community component.

Given the existence of complex family structures in Haiti, excessively rigid criteria as to: 1) who may submit a claim; and 2) who qualifies as a beneficiary among relatives of the deceased person, would prevent a significant portion of victims and their families from accessing the process. As such, any member of the victims' immediate family – partners (official or otherwise), children (biological or otherwise) and close relatives of the deceased – should be entitled to submit a claim and be considered a potential beneficiary under the package. The modalities for dividing the allocated amount among family members should be fixed and predetermined to limit the risk of conflict.

As for the applicable standard of proof, the study proposes that the balance of probabilities standard be used, in that it would allow both a fair and rigorous determination of victims' claims. While medical and practical considerations suggest that, for survivors aged 2 or over, victim status could be determined based on the official medical definitions used by the MSPP at the relevant time period, a differentiated examination of victims' claims by time period would impose an excessive burden of proof on victims, contribute to the re-victimization of PSVs and significantly increase the complexity of the mechanism for processing applications. Therefore, survivors in this age group should be considered victims if they can show on the balance of probabilities that their situation met the definition of "suspected case" of cholera in force prior to 2017.

With respect to deaths of persons 5 years of age or older, a presumption that the death was caused by cholera should apply if the applicants can show on the balance of probabilities that the death occurred about a week following reported symptoms. In more complex cases, such as the deaths of children under age 5, the study emphasizes that it is possible to make up for limitations in proof by referring to circumstantial data, such as the severity of symptoms, epidemiological data on outbreaks, and other relevant circumstantial information. In these cases, the study also proposes that a more flexible standard of proof be applied.

Applicants should provide proof of: 1) their identity, 2) their status as a victim, and, if applicable, 3) their filiation with the victim. As a majority of victims do not always have these types of documents in their possession, the system should not depend only on formal written proof. In general, the following evidence could be admitted: a national identity card or a declaration under oath by the applicant that he or she lacks documents; any documentation attesting to the illness or death, or a sworn statement by a witness coinciding with the applicant's account of the facts; documentary evidence relating to filiation, cohabitation or economic dependence, or testimony by a credible member of the community attesting to the family relationship.

In addition to an effective communication plan accessible to the population, the process proposed by the study to assist victims consists of six (6) steps: 1) filing the claim and preparing the victim's file at the local level; 2) cross-checking information with the formal data system at the regional level; 3) verification of unregistered victims with local sources; 4) sending investigators for more complex cases; 5) the final decision rendered by a centralized unit; 6) the review procedure (only in case of a palpable and overriding error).

Finally, the study proposes a process for determining the amounts awarded to victims, namely the use of statistical sampling to assess damages and set an amount per family. In a context of limited resources and given the large number of victims, it is clear that no amount would adequately address the multiple personal and gender-specific suffering of victims and the significant economic consequences associated with the disease. In this regard, the amount of financial assistance, which is symbolic in nature, should be able to help beneficiaries overcome the most serious consequences of the illness or loss of a loved one. While a payment in the form of multiple instalments poses certain significant administrative problems, its spread over a longer period of time would reduce the risk of theft and fraud, while promoting better management of the sums by the beneficiaries and, in the long term, their stability and financial autonomy.

As to how amounts should be allocated among the family members of a deceased person, determining in advance the terms of the allocation for each family member would reduce the risk of family conflict by limiting the decision-making power of influential members. The findings of this study indicate that the amounts should be distributed first to the mother of the victim's children or the victim's surviving spouse, to his or her children and then to the victim's parents.

Recommendations:

1. In accordance with international human rights standards and the guidelines set out in the UN's *New Approach to Cholera in Haiti*, the UN should ensure that the priorities, needs and concerns of cholera victims are considered and addressed, with particular attention to those of women and girls, when designing and implementing any form of material and financial assistance for them;
2. The UN should develop a mixed approach, including complementary collective and individual assistance components, to address the individualized suffering of cholera victims, to take into account the consequences of cholera for the community and to mitigate the risk of family and community conflicts;
3. As part of the implementation of the individual component, the UN should prioritize as beneficiaries the immediate entourage of people who have died of cholera, in particular women, children, youths and those who have lost a breadwinner in their families; and consider survivors as the second priority group, in particular those who are still living with sequelae of the illness;
4. As part of the implementation of the collective component, the UN should specifically take into account the needs of the victims most affected by cholera, with particular attention to those of women and girls, as well as needs that cannot be targeted by an individual component;
5. The UN should consider the use of symbolic measures to fully recognize the specific suffering of victims and its responsibility for the cholera epidemic in Haiti;
6. To identify cholera victims, the State should develop a database consolidating information held by patient care facilities, and mobilize informal information networks in order to complete and verify existing data, particularly about persons who became ill or died outside of the formal health structures;
7. The UN should set up a simple, rigorous, transparent and inclusive mechanism for a complementary individualized assistance package that is adapted to the contextual realities of the country, including the complexity of family structures, by developing flexible criteria for determining who can be considered a beneficiary;
8. The UN should take into account the limited access to written documents and encourage the use of a combination of physical evidence, testimony, contextual information and presumptions to establish victim status;
9. The UN should determine in advance the terms and conditions and the amount payable to each family to help overcome some of the harmful consequences of cholera;
10. The UN should set up a process for consulting and actively involving the victims and community members affected by cholera at every stage of the design and implementation of an individualized assistance mechanism, and develop measures to encourage the participation of women and girls and take into consideration their specific needs arising from the gender-specific impact of cholera.

INTRODUCTION

A) BACKGROUND ON THE OUTBREAK OF THE CHOLERA EPIDEMIC IN HAITI AND ITS TRAJECTORY

In 2004, the United Nations (UN) Security Council (SC) adopted Resolution 1542 establishing MINUSTAH.[1] As part of the mission's troop rotation, on October 9, 12 and 16, 2010, a contingent of peacekeepers from Nepal – where cholera was endemic at the time – set up camp in the Meille zone, near the town of Mirebalais in the department of Centre.[2] On the following October 19 and 20, a large number of cases of acute diarrhoea were reported in the departments of Centre and Artibonite.[3] On October 21, 2010, the Haitian government declared a cholera epidemic, which was spreading at an alarming rate.[4] In January 2019, the official number of persons infected since the beginning of the outbreak was estimated at almost 820,000 individuals, representing an infection rate of about 6.5% of the total population of Haiti,[5] and the number of deaths at almost 9,800, not including deaths that were not recorded because they occurred in the infected person's home.[6]

While it is true that the incidence of the disease has declined significantly since the start of the epidemic, cholera is still present in Haiti and continues to infect new victims. According to the UN, "the country remains extremely vulnerable to cholera. Root causes of the epidemic remain. Only 25 per cent of the Haitian population has access to adequate sanitation, only 58 per cent has access to safe water and access to health-care services is limited."[7] Thus, in 2018, the formal data recorded almost 4,000 new cases of cholera and almost 50 deaths, with the departments of Artibonite and Centre being the hardest hit.[8]

B) THE UN'S ROLE AND RESPONSIBILITY IN THE FILE

Since the start of the epidemic, a number of scientific studies, including those carried out within the UN system,[9] have confirmed the role of the Nepalese peacekeepers on the MINUSTAH mission in triggering the cholera epidemic in Haiti. These studies showed that: the UN health control protocol did not include appropriate prophylactic[10] measures to avoid

1 *Resolution 1542* (MINUSTAH), Off Doc UN Security Council 4961st meeting, UN DOC S/RES/1542 (2004).

2 Joseph, M. et al., *Petition for Relief* (November 3, 2011), available at: ijdh.org <http://ijdh.org/wordpress/wp-content/uploads/2011/11/englishpetitionREDACTED.pdf>, p. 6.

3 Alston, P., *Report of the Special Rapporteur on extreme poverty and human rights*, Off Doc, UN General Assembly, 71st Sess., UN DOC A/71/367 (2016), p. 7.

4 Transnational Development Clinic, *Peacekeeping without Accountability:* The United Nations' Responsibility for the Haitian Cholera Epidemic, 2013, p. 8.

5 MSPP, *Rapport du Réseau National de Surveillance du Choléra* (January 2019) available at: mspp.gouv.ht <https://mspp.gouv.ht/site/downloads/Profil%20statistique%20Cholera%20 1ere%20SE%202019.pdf>.

6 Moreover, according to a study done by Doctors Without Borders, the mortality rate could actually be three times the rate reported by the MSPP between October 2010 and April 2011 in official statistics (New Approach, 2016, p. 16).

7 *Report of the Secretary-General on the United Nations Stabilization Mission in Haiti, Off Doc,* UN Security Council, 2017, UN DOC S/2017/223, p. 15.

8 MSPP, *supra* note 5, pp. 6-7.

9 Alston, P., *supra* note 3, p. 8.

10 Prophylactic measures are "all the methods directed at protecting individuals or populations from certain epidemic diseases." Such measures include immunization, control of vectors of transmission, screening, and isolation and treatment of contagious cases (translated from definition in Universalis, 2019).

such an outbreak; the sanitation facilities at the camp were deficient and reportedly allowed water contaminated by fecal pathogens to contaminate the soil and watercourses in the vicinity; equipment intended to ensure water quality was improperly maintained and stored; despite tests showing the presence of fecal pathogens, the protocol for treating waste water with chlorine was not followed.[11] Thus, there is currently scientific consensus that, by their negligence, the peacekeepers contaminated the Artibonite River with the bacterium responsible for cholera by discharging human waste into the water, thereby causing a massive outbreak throughout the country.[12]

Despite concerted action by various civil society groups to obtain reparations between 2010 and 2016, the UN rejected the victims' compensation claims before the internal organs of the UN and did not set up the standing claims commission required by the MINUSTAH constituting act.[13] This attitude accentuated the victims' sentiment of injustice and caused discontent in the Haitian population, the UN having previously acknowledged that "the outbreak of cholera … has had a negative impact on … the public perception of MINUSTAH."[14]

In February 2016, Gustavo Gallón, the Independent Expert of the Human Rights Council on the situation of human rights in Haiti reiterated that efforts to eradicate cholera in Haiti should be redoubled and "a commission for redress should be created, as a matter of urgency", to quantify the harm done, establish compensation, and identify responsible parties in accordance with universal human rights principles.[15]

In August 2016, Philip Alston, Special Rapporteur on extreme poverty and human rights, published a report in which he stated that there was overwhelming scientific evidence pointing to the UN's role in the cholera outbreak, writing that "the legal position of the United Nations to date has involved denial of … responsibility …, rejection of all claims for compensation, a refusal to establish the procedure required to resolve such private law matters, and entirely unjustified suggestions that the Organization's absolute immunity from suit would be jeopardized by adopting a different approach. The existing approach is morally unconscionable, legally indefensible and politically self defeating."[16] He went on, it is essential that the UN's new approach "respect the human rights of the victims while protecting the [UN]'s immunity, honouring its commitment to the rule of law and upholding the integrity of the peacekeeping system."[17]

These were the circumstances in which, on August 19, 2016, the UN admitted its "moral responsibility" for the outbreak[18] and the following December 1, it presented its formal apology to the people of Haiti:

"The United Nations deeply regrets the loss of life and suffering caused by the cholera outbreak in Haiti. On behalf of the United Nations, I want to say very clearly: we apologise to the Haitian people. We simply did not do enough with regard to the cholera outbreak and its spread in Haiti. We are profoundly sorry for our role."[19]

11 See, for example, Faucher, B. and Piarroux, R. *The Haitian Cholera Epidemic: is Searching for its Origin Only a Matter of Scientific Curiosity? (2011) 17(4) Clin Micro & Inf 479; Hendriksen, R. S. et al., Population Genetics of Vibrio cholerae from Nepal in 2010: Evidence on the Origin of the Haitian Outbreak (2011) 2(4) Am Soc Microbio 1; Jenson, D. et al., Cholera in Haiti and Other Caribbean Regions, 19th Century (2011) 17 Emerging Inf Dis 2130; Pavoni, R., Choleric Notes on the Haiti Cholera Case (2015), 19 Questions Int'l L 19; Piarroux, R. et al., Understanding the Cholera Epidemic, Haiti (2011) 17 Emerging Inf Dis 1161.*

12 *Ibid.*

13 *Agreement between the United Nations and the Government of Haiti concerning the status of the United Nations operation in Haiti (Headquarters Agreement), July 9, 2004, 2271 UNTS 236 [came into force: July 9, 2004], Art. 54-55; O'Brien, P., UN dismissal of IJDH claims (February 21, 2013), available at: ijdh.org <http://www.ijdh.org/wp-content/uploads/2011/11/UN-Dismissal-2013-02-21.pdf>; O'Brien, P., UN's response to IJDH challenge (July 5, 2013), available at: ijdh.org <http://www.ijdh.org/wp-content/uploads/2013/07/20130705164515.pdf>; Georges v United Nations, case 15-455, document 257-1 Dist Ct (2d Cir 2016) available at: ijdh.org <http://www.ijdh.org/wp-content/uploads/2011/11/2d-Circuit-Decision.pdf>, pp. 4-5.*

14 *Report of the Secretary-General on the United Nations Stabilization Mission in Haiti, supra* note 7, p. 11.

15 Human Rights Council, *Report of the Independent Expert on the situation of human rights in Haiti, Off Doc, UN General Assembly, 31st Sess, UN DOC A/HCR/31/77, p. 18.*

16 Alston, P., *supra note 3, p. 2.*

17 *Ibid. p. 4.*

18 Jonathan M. Katz, U.N. Admits Role in Cholera Epidemic in Haiti, The New York Times (August 17, 2016), available at: NYTimes.com <http://www.nytimes.com>.

19 Secretary-General's remarks to the General Assembly on a *New Approach to Address Cholera in Haiti,* December 1, 2016.

C) THE UN'S NEW STRATEGY FOR CHOLERA IN HAITI AND THE CURRENT SITUATION

In conjunction with these public statements and in an attempt to "address many of the concerns raised in the [Alston] report,"[20] the Secretary-General (SG) presented the UN's "New Approach to Cholera in Haiti" (hereinafter the "New Approach"). The United Nations New Approach "is intended to intensify efforts to eliminate cholera from Haiti and assist and support those most directly affected."[21] One of the central tenets of the New Approach is to "put victims at the centre of the work and be responsive to their needs and concerns."[22] It is estimated that the implementation of this strategy will cost over $400 million, to be funded by a voluntary contribution fund set up in October 2016.[23]

The *New Approach* proposes a two-pronged action plan. Track one, entitled "*Eliminating cholera from Haiti*" aims to "intensify the immediate efforts to decrease the transmission of cholera and improve access to care and treatment (Track 1A); and address the longer term issues of access to clean water, sanitation and health care systems (Track 1B)."[24] Essentially, it is a commitment to "a greatly intensified and better resourced effort [nationally and internationally] to respond to and reduce the incidence of cholera in Haiti."[25]

Track 2, entitled *"Providing a package of material assistance and support,"* is intended to "reflect the Organization's recognition and acknowledgement of the suffering of the people of Haiti due to the cholera outbreak and its commitment to assist and support those most directly affected. It is aimed at providing a meaningful … response to the impact of cholera on individuals, families and communities"[26] and is divided into two elements, a community approach and an individual approach.

Under the community approach, local capacity to effectively combat cholera transmission risks would be strengthened through various projects and initiatives. Under the individual approach, one consideration has been the payment of financial assistance to the families of those individuals who died of cholera. If this approach were adopted, "payment or cash transfer could take the form of a fixed amount per deceased individual that would be the same for each household, regardless of the number of family members in the household."[27]

In developing the material assistance and support package, the SG pledged "to consult with victims and their families and communities …"[28] particularly with respect to a possible individual approach. According to the *New Approach,* this option "would require further consideration, including through consultations in the field with victims and their communities, while recognizing the significant challenges, risks and constraints,"[29] and "the mechanisms by which the data limitations [for victim identification] might be addressed would require further consideration and elaboration."[30] The *New Approach also proposed the submission of additional reports to the General Assembly, in particular concerning the "costs and risks of including an individual approach as an element of Track 2."*[31]

20 Alston P., *supra* note 3., p. 2.

21 UN Secretary-General, A New Approach to Cholera in Haiti, Off Doc UN General Assembly, 71st Sess., UN Doc A/71/620 (2016) [New Approach], p. 3.

22 *Ibid.* p. 8.

23 UN News site, UN launches new fund to support system-wide coordinated response to cholera in Haiti (October 17, 2016) available at: un.org <https://news.un.org/en/story/2016/10/543012-un-launches-new-fund-support-system-wide-coordinated-response-cholera-haiti/>.

24 UN Secretary-General, supra note 21, p. 9.

25 *Ibid.*, p. 3.

26 *Ibid.*, p. 11.

27 *Ibid.*, p. 14.

28 *Ibid.*, p. 11.

29 *Ibid.*, p. 15.

30 *Ibid.*, p. 15.

31 *Ibid.*, p. 16.

Since that time, much progress has been made on Track 1 of the *New Approach,* contributing significantly to a large decrease in the number of cholera cases and deaths.[32] The UN has also made efforts to implement Track 2 by advocating for an essentially community approach. In May 2017, a report mentioned that there had, as yet, been no consultations between the UN and the victims, their families and communities due to a lack of funding,[33] and that the UN would proceed with "one or more symbolic community projects in Mirebalais" as part of Track 2.[34]

The UN did set up a pilot project in Mirebalais, which includes support for five community initiatives identified during the consultations with members of communities that were affected by cholera.[35] The UN now plans to expand this approach to 20 priority communes in the departments of Artibonite and Nord. According to the SG's Special Envoy to Haiti, an additional $27 million is required to implement this approach in the 134 communes concerned.[36]

Track 2 of the *New Approach* is an unprecedented endeavour for the UN and would provide a response to the cholera epidemic in Haiti. To date, the UN appears to be moving toward a community-based approach due to difficulties associated with the feasibility of an individual approach. For example, the UN has mentioned that it does not have "firm assurance of adequate funding to cover the cost of the mapping, registration and verification exercises and [payment] of a meaningful fixed amount per cholera death" and that, in addition, "the views expressed by potential donors and operational partners indicate that this approach is most unlikely to be supported."[37] Despite the UN's initial commitment, it must be said that the victims have not as yet been consulted on the appropriateness of including an individual component in the package of material assistance and support, and the best ways to remedy their personal suffering.

D) THE RELEVANCE OF A FEASIBILITY STUDY ON THE INDIVIDUAL APPROACH

Victims and members of civil society have expressed concern that the approach favoured by the UN appears to be moving further and further away from its commitment to a victim-centred approach.[38] If the objectives of Track 2 are to be met, consideration must be given to the challenges of implementing an individual material assistance component. Several practical difficulties have been identified by the UN, particularly as regards the funding and feasibility of such an approach.[39]

32 The incidence has fallen from 34.45 in 2011 to 0.30 in 2018 according to official MSPP data (MSPP, 2019, p. 6.).

33 UN Secretary-General, A New Approach to Cholera in Haiti, Off Doc UN General Assembly, 71st Sess., UN Doc A/71/895 (2017), p. 10.

34 *Ibid.*

35 *Report of the Secretary-General on the United Nations Mission for Justice Support in Haiti,* Off Doc, UN Security Council 2018, UN DOC S/2018/1059*, p. 4.

36 Multi-Partner Trust Fund, Minutes of the 3rd Meeting of the Advisory Committee of the UN Haiti Cholera Response Multi-Partner Trust Fund (February 2019) available at: mptf.undp.org <mptf.undp.org/document/download/21173>, p. 5.

37 UN Secretary-General, supra note 33, par. 54.

38 IJDH et al., Haiti Cholera Victims' Right to a Remedy (July 16, 2018), available at: ijdh.org <http://www.ijdh.org/wp-content/uploads/2018/07/Letter-to-UNSG-re-right-to-a-remedy_Final-EN.pdf>.

39 *Ibid.*

That being the case, an in-depth examination of the feasibility of the individual component of the material assistance package will ensure that:

1. The UN has access to reliable data in order to develop an effective and adapted response to address the consequences of the epidemic;
2. The Member States and the providers of funding have all the information they need to make informed decisions, especially with regard to funding;
3. Decisions concerning the development and implementation of the package of material support and assistance will be based on the opinions and priorities expressed by the victims.

The UN currently has "an opportunity with the *New Approach* to help rebuild the lives of thousands of cholera victims and set an … example that … will embody the principles of human rights and rule of law that it promotes to others."[40] A victim-centred approach would help empower the victims and let them stand on their own feet, strengthen the UN's reputation and credibility in Haiti[41] and internationally, and actively encourage Member States and providers of funding to support the approach financially.

These are the circumstances in which this study was conducted. It attempts to analyze in a realistic and pragmatic fashion the feasibility of an individual approach, by considering the benefits, risks and challenges associated with its implementation. Regarding the guiding principles contained in the *New Approach,* this study identifies the needs, expectations and priorities of those most affected by the epidemic as they relate to the implementation of material and financial assistance. As a complement to the community initiatives currently in progress, this analysis offers practical recommendations for implementing an approach centred on the individual. These recommendations aim to contribute to the effectiveness and acceptability of the package developed by the UN to assist those most severely affected by the epidemic.

40 *Ibid.*

41 Alston, P., *supra* note 3, p. 20.

METHODOLOGY

In this study, we have combined several methods to analyze the feasibility of an approach centred on the individual.

PART 1: VICTIMS' PERSPECTIVES ON THEIR NEEDS, EXPECTATIONS AND PRIORITIES

Before analyzing the feasibility of an individual approach, the study examines the victims' opinions of the various options initially envisaged by the UN in terms of material and financial assistance. To this end, a preliminary documentary analysis was made of the social, political and economic issues raised by the cholera epidemic in Haiti, and research was conducted in the field by the Interuniversity Institute for Research and Development (INURED).[42] This research included interviews with key individuals, notably community leaders, and discussion groups with between 6 and 10 participants each. In order to take part in the study, the participants had to 1) have experienced at least one cholera death in their family; or 2) be cholera survivors themselves or be part of a household in which one or more persons had contracted cholera. INURED conducted 22 individual interviews in Creole and 15 group discussions with 97 participants in the regions of Port-au-Prince, Saint-Marc, Mirebalais, Chambellan, Anse d'Hainault and La Chapelle between July and October 2017 (See Appendix 1: Matrix from Study on Victims' Point of View). Following a pre-established guide, these interviews and group discussions were held in appropriate neutral locations where the participants could speak freely. To ensure methodological consistency, the overall purpose of the study was always described in the same way.[43] The participants were also told that their participation presented no immediate advantage and were asked to sign a consent to participate.[44]

This part of the study was later completed by four "life stories" of cholera victims, recorded by a Haitian sociologist in order to gain a better understanding and illustrate the life experience of individuals affected by the disease, including the associated stigmatization and their social, institutional and non-institutional trajectory.[45]

42 Comprised of a diverse group of academic and applied researchers in social sciences, policymakers as well as community leaders from all segments of Haitian society, INURED is a research institute that aims to democratize access to scientific knowledge. Created in May 2007, the Institute is founded on principles of independence, interdisciplinarity, application, transnationality, collaboration and transparency, with the aim of contributing to the development of advanced scientific research and science education in Haiti in order to improve the educational, socio-economic and political condition of Haiti's people.

43 This is what was said: "The purpose of the project is to carry out a detailed feasibility study to analyze the benefits, risks and feasibility of various options for providing material assistance to the victims of cholera in Haiti and methods of administration, implementation and follow-up." Moreover, the researchers clearly explained that the study would provide practical information required for the stakeholders so that they could "determine the benefits, risks and feasibility of various options for providing material assistance."

44 The form was approved by INURED's Institutional Review Board and clearly set out the objectives of the study, the participants' right to withdraw from the discussion groups at any time or to interrupt the interview process and a guarantee of confidentiality and protection of the human subjects. It was read to the participants and discussed with them in Creole.

45 Three women and one man participated in this process. Two of the participants were direct cholera victims who survived the disease and three of them were indirect victims who directly cared for at least two victims of the disease (one of the participants was a survivor of the disease who had also cared for several family members who contracted the disease).

Although the study was intended chiefly to assess the feasibility of an individual approach, it should be noted that all the opinions of the participants about the various approaches (individual, community and mixed) were gathered and analyzed with the same rigour, including when a participant would bring up one of these approaches as a comparison in order to qualify or reject the other approach. In addition, to limit methodological biases and avoid influencing the participants' responses, the same questions[46] were asked in the same way twice, once using the term "individual" and the other using the term "community" (See Appendix 2: List of Questions for Interviews on Victims' Point of View).

PART 2: FEASIBILITY ANALYSIS OF AN INDIVIDUAL APPROACH

The feasibility analysis of an individual approach was conducted by an LWBC team with support from the Haitian sociologist. It is based on a review of the documentation and on various interviews.

Review of the documentation

Existing documentation on large-scale compensation initiatives implemented in other similar contexts was reviewed, with particular attention to the basic principles, means and standards of proof, as well as the distribution methods used.

Field Interviews

In addition, more than 30 semi-directed interviews were conducted with various actors who were involved at various levels in the formal and informal management of cholera (including epidemiological tracking, prevention or treatment of the disease). In addition to the interviews conducted in Port-au-Prince and the Ouest department, three field trips were organized, lasting 3 to 5 days each: to Quartier-Morin and its surrounding area (Nord) from May 2 to May 5, 2018; to Saint-Michel-de-l'Attalaye and its surrounding area (Artibonite) from May 8 to 11, 2018, and to Dame-Marie and its surrounding area (Grande-Anse) from May 20 to 25, 2018.[47] These interviews, like the previous ones, were conducted in Creole in appropriate locations and all the participants consented after being informed of the overall purpose of the study as defined above, knowing that they would not benefit from partaking in the process. Telephone interviews were also conducted with five international experts on questions specific to cholera in Haiti and on the challenges and lessons learned from the implementation of large-scale compensation and cash transfer programs.

All these interviews were conducted using the specific interview scripts (See Appendix 3: Interview Scripts for the Feasibility of an Individual Approach) and principally targeted the following classes of persons:

46 The questions asked related principally to the following subjects: the circumstances in which cholera emerged and its impact on their families; identification of the hardest hit victims and the impact of cholera on the victims' lives; direct assistance from the UN to cholera victims and its potential benefits; the feasibility of a direct assistance approach; risks associated with a direct assistance approach; risk mitigation strategies for the direct assistance approach.

47 These communes were selected based on the MSPP's official epidemiological data in order to reflect the different dimensions of cholera, particularly as regards the specific characteristics of certain regions (urban or rural environment, demographics, accessibility of potable water, accessibility of health care, etc.). These areas were selected inter alia to reflect the reality of the capital and its surroundings (Port-au-Prince); an area relatively close to an urban centre where a high incidence of cholera was reported multiple times following the initial outbreak of the epidemic (Quartier-Morin); a rural area that was difficult to access where the recorded incidence was among the highest nationally (Saint-Michel-de-l'Attalaye); an area impacted by Hurricane Matthew where a high incidence was reporded multiple times following the initial outbreak of the epidemic (Dame-Marie).

1. Officials of State[48] and non-State institutions (such as international and non-governmental organizations)[49] whose task was to treat patients with cholera or to collect information about the victims. The purpose of these interviews was to:
    a. better understand how the formal health care system was designed;
    b. determine how much information the formal health care system had recorded and kept concerning cholera patients and deaths, in order to get a general idea of the state, nature and extent of existing documentation in the formal system.
    c. identify the strengths of the formal system in order to consider how it could be mobilized to trace and identify cholera victims, but also the gaps that would have to be filled in by other mechanisms.
2. Local authorities[50] and various community leaders, including local elected officials; dignitaries and other informal local authorities; representatives of victims', women's and peasant farmers' associations;[51] pastors and priests; *houngans and mambos;*[52] midwives, etc. These interviews helped to:
    a. better understand how the informal and community system works, including the role played by various actors in taking care of those who are sick;
    b. determine the nature, extent and form of the information available within the system in order to obtain a general picture of the current state of existing documentation;
    c. consider how that information could be mobilized to identify victims and formally verify their information, particularly victims who contracted cholera or died without receiving hospital care;
    d. propose measures that use the informal system to mitigate the risk of conflicts within families or communities.
3. Specialists on subjects such as: the specific issue of cholera in Haiti (local and international physicians and research scientists);[53] the design, development and implementation of large-scale compensation programs in similar contexts (international reparations experts);[54] the design and implementation of cash transfers as part of population support programs (local institutions).[55] These interviews helped to:
    a. obtain information about how such initiatives have been designed and implemented, from a technical, administrative and logistical standpoint in similar circumstances;
    b. compare various relevant experiences in order to identify the principal strengths and weaknesses of these processes and draw relevant lessons.

48 In particular from the DELR, departmental health authorities (health directorates of Grande-Anse and Nord) and local medical staff (physicians, nurses).

49 Including Zanmi Lasante, GHESKIO, Real Hope Haiti, MSF Hollande and MDM France.

50 Including members of the ASEC and CASEC and mayors.

51 Such as BAI, BODDH, ASOVIK, OVICH, MOMVIK, SOFA, AFSDMM, MOFAPEKA, GFP, KAPEGA, APECOQ, OTG, KOFIP, ZANTRAY, DAVVO-Lakou, Lakou Giyode and local notaries and lawyers (including Marie-Alice Bélisaire Coradin, Jacceus Joseph, Mario Joseph).

52 Vodou priests and priestesses.

53 Including Renaud Piarroux, Thierry François, Karine Sévère, Ralph Ternier, Patrick Dely, Jonathan Lawson and Frédéric Gérald Chery.

54 Including Carla Ferstman, Cristián Correa, Julie Guillerot, Eduardo Gonzalez.

55 Including representatives of Fonkoze, Digicel, KOTELAM and SOGEBANK.

c. obtain the opinions and recommendations of experts as to the design of a victim identification process and the implementation of an individualized material assistance package in a context of limited information and financial resources;

d. ensure that the proposed system is adapted to the victims' perspective and to the reality of cholera in Haiti.

PART 1
INTERNATIONAL HUMAN RIGHTS STANDARDS

The *New Approach* proposed by the UN is not a reparations program per se and, therefore, it would be complex to transpose specific standards of victim reparations law directly to the present case. Nevertheless, the principles previously developed by the UN and comparable experiences do offer modalities, procedures and methods that are relevant to the design and adapted implementation of the *New Approach*. Although this study focuses more specifically on the benefits, risks and feasibility of an individual approach to material assistance, these principles should at the very least serve as a guide to the UN in developing a fair and effective response to the Haitian cholera victims.[56]

These principles are generally associated with "the obligation to respect, ensure respect for and implement international human rights law and international humanitarian law",[57] and to provide effective remedies and full and effective reparation for victims.[58] However, beyond their strictly legal application and the resulting judicial procedures, reparations and their governing principles have deeper aspirations. Universal human rights law explicitly acknowledges that "in honouring the victims' right to … reparation, the international community keeps faith with the plight of victims, survivors and future human generations" and recognizes the need for victims to "be treated with compassion and respect for their dignity."[59]

56 *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law [Basic Principles and Guidelines on the Right to a Remedy and Reparation*], Off Doc UN General Assembly, 60th Sess, DOC UN A/RES/60/147 (2006).

57 *Ibid.*, Princ. II(3).

58 *Ibid.*, Princ. IX(18).

59 *Ibid.*, Preamble.

International reparations law establishes basic standards for the proper treatment of victims and their suffering in similar contexts. Those standards have moreover been tested in transitional[60] and reparatory justice situations. For example, adequate reparation is generally "proportionate to and concomitant with the human rights violations and the harm suffered," and "promotes justice by remedying the violations suffered with a view to reconciliation."[61] Reparations are also intended to transform the social dynamics or causes that led to the suffering, and in this sense recognize "the need to restore the relationship between the victims, their community or the [wrongdoers] that was broken by the [wrongs] committed."[62] They focus on the accountability of those who caused the harm and the community's responsibility to both the victims and the wrongdoers.[63] Thus, reparations favour the development of solutions "that are not only acceptable to all the parties, but encourage the development and strengthening of relations between all concerned."[64]

The general principles of reparatory justice recognize that, independently of the context, it is primordial that the reparations adopted (whether they be "material or symbolic, individual or collective"[65]) not be isolated measures but form part of a holistic and multidimensional response to the victims and their suffering. Indeed, the relevance of a multidimensional approach resides in the complementarity of the various measures, in addition to fostering in the victims a sense of satisfaction with the process.[66] In this sense, the general principles and the practice recognize that reparations must be accompanied with "recognition of the responsibility of the wrongdoers" (e.g., public apologies)[67] and be combined with "measures based on the search for truth, the restoration of justice and the adoption of measures that prevent their recurrence."[68] Because they can be perceived as an attempt to buy the victims' consent, reparations made in isolation and without express acknowledgment of the wrongdoers' responsibility for the wrong caused to the victims will not be perceived as reparative.[69]

Reparatory justice acknowledges that "reconstruction and development policies aimed to guarantee social, economic and cultural rights would be partial if the conditions … rights [and specific needs] of victims … are not addressed.… [They] would not be effective if they do not assume an approach of responding to the … socioeconomic and psychosocial consequences of … the [harm].[70] Such a process would be likely to cause tensions and mistrust within the communities, the families and among the actors responsible for its implementation because of the lack of transparency of the selection criteria.[71]

60 The usual objectives of transitional justice are: "recognition of violations of victims' rights; search for criminal, reparational or symbolic justice; the prevention of new crimes; reconciliation; restoration, maintenance or reinforcement of peace, the rule of law and democracy by introducing institutional and political reforms" (LWBC, 2013, p. 19).

61 LWBC, *État des lieux sur la justice transitionnelle au Mali*, Quebec City, January 2016, p. 40.

62 LWBC, *Pour une justice transitionnelle efficace et inclusive: Rapport de consultation sur les perceptions, attentes et besoins exprimés par les victimes du conflit armé au Mali*, Quebec City, 2018, p. 19.

63 Ingenito L. and Pagé G., *Entre justice pour les victimes et transformation des communautés: des alternatives à la police qui épuisent les féministes* (2017) 92 Mouvements, p. 63.

64 Department of Justice, "Challenging the Mainstream: Approaches to Increasing Access to Criminal Justice" in *ReThinking Access to Criminal Justice in Canada: A Critical Review of Needs, Responses and Restorative Justice Initiatives* (January 18, 2018), available at: <https://www.justice.gc.ca/eng/rp-pr/csj-sjc/jsp-sjp/rr03_2/p3a.html>.

65 LWBC, *Le combat de Maliens et des Maliennes pour la paix et contre l'impunité: des recommandations en vue de la mise en place d'une justice transitionnelle adaptée aux besoins du Mali*, Quebec City, 2018, p. 63.

66 LWBC, *De la crise à une paix durable: La justice et les droits humains dans un contexte de transition au Mali*, Québec, 2013, p. 21.

67 It should be noted that to be effective and to adequately address victims' suffering (and hope thereby to have some real social, psychological and/or legal impact) such an acknowledgment must meet certain requirements. First, the harm must be recognized and clearly identified. Those responsible must also fully acknowledge their responsibility and avoid defensive attitudes and justifications, as such attitudes would negate the validity of the acknowledgment and exacerbate the pain felt by the victims. Moreover, such an acknowledgment must demonstrate sincere regret and deep remorse. This will allow the victims to be confident that those responsible truly understand the harm caused and the resulting consequences but also open the way to an eventual forgiveness in addition to restoring a healthy relationship between the victims and the wrongdoers (See, for example, Alter, S., *Apologising for Serious Wrongdoing: Social, Psychological and Legal Considerations*, Final Report for the Law Commission of Canada (May 1999), pp. 18-23).

68 LWBC, *supra* note 61, p. 9.

69 *Ibid.*, p. 44.

70 Correa, C., *Integrating Development and Reparations for Victims of Massive Crimes*, The Center for Civil & Human Rights at the University of Notre Dame (July 2014), p. 25.

71 LWBC, *supra* note 65, p. 63.

It is also essential that reparations "be the culmination of a process of popular consultation"[72] and that they be adapted to the needs of civil society.[73] Universal human rights law recognizes that "in adopting a victim-oriented perspective, the international community affirms its human solidarity with victims of violations …, as well as with humanity at large."[74] In fact, "to the extent that the exercise is an attempt to respond to the victims' expectations, … its success depends first and foremost on real consultation with and participation of the victims. Their opinions and aspirations … should be at the heart of any policy."[75] Inclusive preliminary consultations are also essential "when designing reparations programs, so that the measures adopted actually correspond to the harms that are to be compensated for."[76]

72 LWBC, *supra* note 61, p. 42.

73 All of civil society, especially the direct victims … must be able to contribute to the process and particular attention should be given to the voices of women and youth as PSVs (LWBC, *supra* note 61, p. 21).

74 Basic *Principles and Guidelines on the Right to a Remedy and Reparation, supra* note 56, Preamble.

75 LWBC, *supra* note 66, p. 20.

76 *Ibid.*

PART 2
VICTIMS' PERSPECTIVES, BENEFITS AND RISKS OF THE INDIVIDUAL AND COLLECTIVE APPROACHES

1. CHOLERA VICTIMS' EXPERIENCE AND SUFFERING

It is essential to understand the impact of the disease on the victims in order to properly assess the benefits and risks of the two approaches. Data gathered in the field by INURED reveals that the principal effects on the victims were physical, psychological, social and economic, and that the disease further marginalized populations in situations of vulnerability (PSVs), especially children, the most impoverished and women.

1.1 Physical and psychological impacts

Cholera is a severe intestinal infection caused by the bacterium *Vibrio cholerae,* which if not treated appropriately, can lead to the death of the infected person within a matter of hours.[77] In its acute phase, the disease is characterized by serious diarrhoea and vomiting that lead to severe dehydration.[78] Patients describe it as a terrible sensation that their intestines are being "devoured from the inside".[79] Although there are no scientific studies of the long-term effects of cholera on the body,[80] many of the people interviewed claim that cholera has significantly compromised the general health of those who contracted the disease and subsequently led to a number of other ailments,[81] with most survivors never recovering their former state of health.[82]

From a psychological perspective, during the acute phase of the disease, infected persons reported a feeling of intense panic associated with the physical pain and the sudden and sharp deterioration in their state of health, and even a sensation of imminent death in the most severe cases.[83] Those interviewed said that survivors and close family members of deceased

77 World Health Organization, *Public health risk assessment and interventions: earthquake: Haiti* (December 2010) available at: who.int <https://apps.who.int/iris/bitstream/handle/10665/70221/WHO_HSE_GAR_DCE_2010.1_eng.pdf> [Report on the public health risks after the earthquake], p. 5.

78 Although most infected people do not display any symptoms, the bacterium remains present in the feces or vomit for 1 to 10 days, which presents risks of environmental contamination (particularly through water) and increased transmission in the population (WHO, 2010).

79 Interviews of cholera victims by INURED (July to October 2017). Port-au-Prince, Saint-Marc, Mirebalais, La Chapelle, Chambellan and Anse d'Hainault.

80 Interview of Renaud Piarroux by LWBC (April 3, 2018), Port-au-Prince.

81 Participants mentioned persistent stomach pain and digestive problems as well as the onset of other ailments such as vision problems, anemia and inability to concentrate (INURED, 2017).

82 INURED, *supra* note 79.

83 *Ibid.*

victims were often traumatized in the longer term and continue to suffer psychological consequences, some of which resemble post-traumatic stress disorder. In some cases, particularly in urban areas, psychological distress is so great that it has resulted in alcohol or drug use, particularly by children and young adults.[84]

Those interviewed by INURED repeatedly said that the survivors who continue to suffer from serious physical or psychological effects associated with cholera are among the greatest victims and that this should be recognized. They believe it is essential that whatever assistance program is set up takes the fundamentally private and personal aspect of such suffering into consideration.

1.2 Social impacts

The victims also emphasize the social impacts of the disease. It is a form of humiliation and an assault on their human dignity. People who contracted cholera are often rejected by their close family members and isolated from their community:

"There are still families that give different plates and spoons to people [in their household] who have been sick. When some children who have had cholera sit near their classmates, they are humiliated. Their classmates move away. They even call them "Cholera". The word has become an insult."[85]

While some victims, overcome with shame, chose not to receive treatment and to stay hidden at home, others were abandoned by their families at health centres.[86] Some people face significant social repercussions simply due to their condition:

"Cholera is a very stigmatizing and humiliating disease. People think it's a disease of unclean people. My son, my wife and I had cholera. After leaving the CTC, the neighbours with whom we had had cordial relations refused to greet us and to shake our hands. They asked our landlord to evict us from the courtyard where we lived."[87]

1.3 Victims' perspectives on the "hardest-hit victims"

Although the physical, psychological and social consequences described by the persons interviewed were relatively similar, they emphasized that the impact of cholera was variable from one family or community to another. Infected or deceased persons were not all affected in the same way. The participants identified two classes of victims who suffered most from the disease. First, almost all those who were interviewed agreed that the families of people who died from cholera were the hardest-hit victims. Then they identified cholera survivors as the second hardest-hit victims.[88]

The participants believe that the close family members of the deceased are the greatest victims due to the significant economic repercussions caused by the death of their relative, particularly in populations whose economic situation is precarious. The families of deceased victims are often unable to get back on their feet financially.[89] In this connection, it should be

84 *Ibid.*

85 *Ibid.*

86 Partners in Health, *Mourning cholera victims* (2011) available at: pih.org <https://www.pih.org/article/mourning-cholera-victims>.

87 INURED, *supra* note 79.

88 *Ibid.*

89 *Ibid.*

noted that even within this class of victims, the participants recognize that the families of deceased victims have been affected in different ways: some families have lost their principal breadwinner or another family member who made a significant contribution to the household income, thus leading to a substantial increase in the economic obligations of another family member, whereas in other cases people have contracted large debts to pay for private care or for the burial of the deceased person.[90] A preliminary study in this regard that was carried out between August 2011 and May 2013 reported that 100% of the families surveyed who had paid for the funeral of a close relative who died of cholera had had to borrow money.[91] In a situation where there is absolutely no financial assistance from the State, these debts accumulate and become difficult for families to pay off.[92]

Survivors face a similar situation, in that chronic suffering was sometimes reported as being so incapacitating that it prevented the victims from working or caused them to become disabled, thus leading to a loss of their means of subsistence and economic opportunities.[93]

However, the participants considered that the degree of suffering associated with the death of a close relative was greater than that associated with the consequences suffered by the survivors of the disease.

The participants also said that certain classes of vulnerable people appeared to have been particularly affected by the economic effects associated with the death of a cholera victim. Most participants identified an explicit hierarchy even within the class of "the hardest-hit victims", as follows: 1) minor children and young adults who lost a parent or breadwinner, and 2) adults (particularly the spouses of deceased victims) who lost one or more breadwinners in the family.[94] They said that any program set up should take these differences in the degree of harm into consideration.[95]

"if my father were still alive, there are things we would not have had to live through…My father is dead and has left behind my mother and 8 children."[96]

1.4 Increased marginalization of populations in a situation of vulnerability

The reason those interviewed believed there should be a hierarchy among the different types of victims - specifically mentioning the marked suffering of families in a precarious economic situation and children - is because of the way cholera contributed to further marginalizing populations in a situation of vulnerability (PSV).

According to the official data, PSVs appear to have contracted cholera in disproportionate numbers compared with the rest of the population. It is documented that the spread of infectious diseases usually follows structural inequalities in a society.[97] This may be explained by the greater exposure of PSVs to various risks, including those associated with transmission factors and the greater difficulties in preventing and reducing the impact of the disease.[98] This is particularly true of families living in a precarious economic situation and children, as the participants pointed out, but also women and girls.

90 *Ibid.*

91 REDRESS, *Responding to the Introduction of Cholera to Haiti: Policy Options* (June 2016) available at: redress.org <https://redress.org/wp-content/uploads/2017/12/Responding-to-the-Introduction-of-Cholera-to-Haiti.pdf>, p. 13.

92 INURED, *supra* note 79.

93 *Ibid.*

94 *Ibid.*

95 *Ibid.*

96 *Ibid.*

97 See, for example, Farmer, Paul, *Pathologies of Power: Health, Human Rights and the New War on the Poor,* Berkeley, Los Angeles-London, University of California Press, 2003.

98 Eboko, F. *et al. Inégalités et santé: des disparités récurrentes à un projet global?* (2002) Face à face, available at: journals.openedition.org <https://journals.openedition.org/faceaface/487>.

a) Families in a precarious economic situation

The MSPP's official data show a significant correlation between the incidence of cholera and the victims' precarious economic situation, their place of residence and lack of access to certain services and resources, especially drinking water, adequate sanitation, local health services, and information.[99] According to the WHO, "cholera is closely associated with poverty, poor sanitation and lack of clean drinking water."[100] As Philip Alston already mentioned in his report, cholera in Haiti "has had its greatest impact on those living in poverty, who are poorly placed to cope with the consequences of the disease or to take the precautions necessary to reduce the risks involved."[101]

b) Children

Children, from a medical perspective, are more prone to the disease due to their physiological characteristics. Treatment of the disease in children is also more difficult to administer and complications are more frequent.[102]

Those interviewed by INURED identified children who lost a close family member as victims who had suffered particularly, since they face additional obstacles both financially and in terms of access to housing. They also suffer the loss of opportunity in the long term; many have to drop out of school to support their families or survive on their own. In a context of extreme financial precariousness, this appears to have contributed to youth homelessness: youth survive on the streets by offering services,[103] e.g., car washing, in exchange for ridiculously small sums of money.[104] This finding was even more prevalent in the case of many children who were orphaned or abandoned at the CTCs by their parents.[105]

The effects of the disease and the death of a close family member on children's mental health was also especially marked. The participants interviewed by INURED said that these children, left to their own fate, "have no-one to feed them and educate them," especially if there are no other family members willing to care for or help them, thus encouraging juvenile delinquency.[106]

c) Women and girls

Although the MSPP's data is not broken down by gender, more women than men probably contracted the disease, particularly at the beginning of the epidemic, considering the gender-based division of roles in the home and professionally. Women were thus more exposed to cholera as a result of their specific tasks in the home and community and their predominance as front-line caregivers.[107]

As a general rule, the division of tasks within the home means that women are usually responsible for taking care of family members who are sick. They are the ones providing care,

99 See, for example, Ministère de la Santé Publique et de la Population, *Plan d'élimination du choléra en Haïti* (November 2012) available at: mspp.gouv.ht <https://mspp.gouv.ht/site/downloads/Plan_elimination_du_cholera_2012_2022.pdf>.

100 WHO *Cholera: Vaccine Preventable Diseases Surveillance Standards* (September 2018), available at: who.int <https://www.who.int/immunization/monitoring_ surveillance/burden/vpd/WHO_SurveillanceVaccinePreventable_02_Cholera_R1.pdf>, p. 3.

101 Alston, P., *supra* note 3, p. 5.

102 Doctors Without Borders, *Haïti: Les enfants sont plus vulnérables face au cholera* (2011) available at: MSF.fr <https://www.msf.fr/actualites/haiti-les-enfants-sont-plus-vulnerables-face-au-cholera>.

103 This fear was mentioned several times in interviews conducted by INURED. One can conjecture that the situations associated with youth homelessness were probably similar to those of "children separated from their parents, orphaned or abandoned" after the earthquake, which gave rise to child trafficking, sexual exploitation and exacerbated the situation of children in domestic service (restavèk) (See, for example, ICBR, 2016, p. 3).

104 INURED, *supra* note 79.

105 MSF, *supra* note 102.

106 *Ibid.*

107 This phenomenon has moreover been noted in other contexts, for example in Liberia during the Ebola epidemic. Epidemiological data showed that at the beginning of the epidemic, women accounted for two thirds of the virus-related deaths. Researchers attributed this disparity to the fact that women "were in the front lines in caring for patients at home or in care facilities" (See, for example, Bienvault, 2014, online).

thereby increasing their own risk of infection. According to many of the survivors interviewed by INURED, the women who cared for them subsequently fell sick themselves[108] Moreover, in Haiti, women and girls use water for most domestic work. They may have come into direct or indirect contact with the bacterium when washing the victims' and deceased persons' clothes and bedding or when washing bodies during funeral rites.

Women in Haiti play a predominant role in health facilities as nurses or nursing assistants. Most front-line caregivers are women, which means that they work in close contact with cholera patients. More women than men also work as vendors in insalubrious public markets and travel in difficult conditions, sometimes even being vectors for the transmission and spread of the disease. They are thus at greater risk of contracting the disease when purchasing and reselling their products.[109]

"I am a vendor at the Cap market. I think that's where I caught the cholera microbe. The market is so dirty that I have my feet in dirty water and mud all day. I don't have any choice. It's either earn my living or take care of my health."[110]

It should be noted that only 25% of Haitian women have regular remunerated work[111] and that over 42% of women have no money of their own that they can spend without permission.[112] Only 35.8% of Haitian women own property (in sole or joint ownership) and 12.4% of them can sell it without permission.[113] In this respect, many Haitian women live in extremely precarious financial conditions.[114] Women who do not work and single women are generally less financially independent (and are therefore more often in a situation of economic dependence on third persons.)[115]

In these circumstances, women who lost their family breadwinner, generally their husband or partner, had to find other ways to cover the family's subsistence costs. On the other hand, the economic impact on men tends to be less and they can ask another woman in the family to perform household tasks if their wife or partner dies. Women often have to give up their economic activities or education in order to look after the household.[116] If a close family member dies, women and girls suffer significant moral and economic harm.

Thus, we can say that certain factors associated with different classes of PSV, notably social class, geographical location, age and gender, were linked to a disproportionate rate of infection relative to the rest of the population, exacerbating existing inequalities. Families living in a precarious financial situation, children, women and girls were especially affected by the cholera epidemic.

108 Field mission interviews (May 2 to 25, 2018), Port-au-Prince, Quartier-Morin, Saint-Michel de l'Attalaye, Dame-Marie.

109 INURED, *supra* note 79.

110 Lamour et al., *supra* note 108.

111 MSPP, *Profil des femmes en Haïti: Résultats de l'Enquête Mortalité, Morbidité et Utilisation des Services EMMUS-III 2000* (November 2002) available at: dhsprogram.com <https://www.dhsprogram.com/pubs/pdf/OD27/ProfildefemmeHaiti.pdf>, p. 4.

112 *Ibid, p. 6.*

113 *Ibid.*

114 Apart from the strictly monetary aspect of poverty, the determining factors are both "associated with the sociodemographic and economic characteristics of the woman and her household: the size of the household, the number of children in school, the number of unqualified adults who have no working income and the household's land and livestock assets." The financial precarity of Haitian women is thus more marked as well as multifactorial, which makes them even more likely to be economically dependent (See, for example, Thomas, S. *De la pauvreté multidimensionnelle des Femmes en Haïti (Chansolme): analyse et impact d'une stratégie de lutte,* Master's thesis, Faculty of Agricultural and Food Sciences, Université Laval, 2012).

115 MSPP, *supra* note 5.

116 Lamour et al., *supra* note 108.

2. THE INDIVIDUAL APPROACH: BENEFITS

2.1 Responding to the needs of the hardest-hit victims

In light of the field interviews that were conducted, it appears that the victims consider some of the suffering they experienced to be of a private and personal nature, as well as an affront to their human dignity. Furthermore, considerable inequalities exist in: the distribution of the victims (PSVs being disproportionately infected); the types of suffering experienced (particularly the victims' ability to prevent and fight the disease); and the specific way in which this suffering was experienced depending on the particular circumstances of each person or family.[117]

INURED's consultations showed that preferences for financial assistance varied considerably from one region to another.[118] However, the participants systematically acknowledged the importance of taking into consideration the specific and personal suffering of those who were and continue to be disproportionately affected by the cholera epidemic. Those interviewed were almost unanimous in identifying the close family members of deceased victims and the survivors of the disease as the victims who suffered the most. They also emphasized their particular concern for certain PSVs who lost a close family member, especially children and youth, and individuals whose financial situation became significantly more precarious as a result of cholera. Additionally, they identified the victims who continue to experience serious physical and psychological effects from the disease as the second hardest-hit victims.[119]

Therefore, in order to reflect the victims' needs and priorities, the material assistance and support package should consider the specific suffering of those who are considered the "hardest-hit" victims of cholera, with economic loss as one of the main focus, while being adapted to the special situation of PSVs, especially the children. Although the participants believed that the assistance should benefit the survivors as much as possible, especially those who continue to suffer significant and lasting effects of the disease, they acknowledged that it should be incremental in order to reflect different levels of harm and that, in this respect, the family members of deceased persons should receive more assistance than survivors.[120]

Based on these criteria, the participants thus expressed a preference for a mixed approach that would combine a form of individual assistance with collective measures. According to the participants, individual assistance, for example, in the form of unconditional cash transfers, would permit recognition of the private and personal nature of the victims' suffering, the existing inequities between the various classes of victims and the financial indebtedness that is a central aspect of the suffering experienced.

2.2 Benefits of unconditional cash transfers

Those interviewed indicated a preference for unconditional cash transfers over other forms of assistance. In their opinion, this type of transfer would allow the beneficiaries to make use of the money in accordance with their specific needs, and thus take into account the previously mentioned inequalities. Moreover, the beneficiaries could make the money work for them, giving them an opportunity to invest and engage in economic activities that might generate income and, in the longer term, provide some measure of economic stability and financial

117 INURED, *supra* note 79.

118 The results of this exploratory study suggest moreover that the success of the UN's material assistance packages will depend on their understanding of the communities affected: the make-up of the population, the proportion of temporary residents versus permanent residents, the existence of viable local organizations and their relations with the members of the community and the level of trust between elected officials and the affected communities. These results show that these factors, among others, have a strong influence on the type of assistance that the victims believe is most appropriate (INURED, 2017).

119 *Ibid.*

120 *Ibid.*

independence to the beneficiaries.[121] A number of the interviewees also mentioned that the multiplier effect of direct monetary assistance was of prime importance in Haiti's current economic circumstances, where there are few long-term opportunities in the labour market or for income-generating activities:

"The country doesn't give anyone anything… if I can get a little money, I can use it to make more."[122]

It should be said that these cash transfers, whether they are used in large-scale reparations programs or in simple development programs, have also been tested in other similar contexts characterized by a large number of beneficiaries, limited documentation systems and limited resources.[123] It has been shown that they help reduce stress among the beneficiaries,[124] increase their confidence,[125] and improve the networks and social standing of the beneficiaries.[126] Far from encouraging irresponsible spending, such programs allow families to obtain cash to meet urgent needs and invest directly in basic necessities (such as food and housing), essential goods and services (such as education and health) and small businesses, thereby fostering economic stability and long-term financial independence of the beneficiaries.[127]

When properly designed and implemented, cash transfer programs generally have a greater effect on the overall reduction in poverty and extreme poverty, particularly where community projects and income-generating programs have not had the hoped-for impacts.[128] For example, in South Africa, this type of development program reduced the beneficiaries' poverty by about 47%.[129] In Haiti, when cash transfers were introduced by Christian Aid, 93% of the funds distributed were spent on essential products, goods and services, which helped to improve the beneficiaries' living conditions and stimulated the economy.[130]

This benefit is even more important because it reaches a large number of individuals affected by the epidemic and addresses a variety of harms.[131] While the choice of a specific form of individualized material assistance for the hardest-hit victims would justify holding further consultations and making more detailed assessments, it should be noted that the high levels of poverty (and consequently the high levels of unmet basic needs), the limitations of the labour market, the limited accessibility of the social safety nets and of financial institutions[132] make unconditional cash transfers particularly attractive in the Haitian context.[133]

121 *Ibid.*

122 *Ibid.*

123 According to Cristián Correa, "Overambitious goals that cannot possibly be fulfilled by the measures can create more resentment and distrust [among victims]. On the other hand, over caution about the limited capacity of the reparations program can be perceived as minimizing the serious nature of the [suffering experienced] and [its] impact. Keeping a balance between these two situations is not easy. Obtaining political support and resources for reparations may require praising the impact and ability of the program to produce change and satisfaction. However, overselling such impact could backfire for victims …. One approach that might help in finding a balance is acknowledging that, despite the efforts being made …, publicly acknowledging to victims that the program is not enough to respond to the consequences of the [suffering experienced], neither can [the measures] be proportional to the harm [suffered]" (Correa, 2014, p. 15-16).

124 Samuels, F. and Stavropoulou, M., *Being Able to Breathe Again: The Effects of Cash Transfer Programs on Psychosocial Wellbeing* (2016) 52(8) J Dev Stud 1099.

125 Tonguet Papucci A. et al., *Beneficiaries' perceptions and reported use of unconditional cash transfers intended to prevent acute malnutrition in children in poor rural communities in Burkina Faso: qualitative results from the MAM'Out randomized controlled trial* (2017) 17(1) BMC Public Health 527.

126 Ressler, P., *The social impact of cash transfers: a study of the impact of cash transfers on social networks of Kenyan households participating in cash transfer programs* (January 2008), available at: ebrary.ifpri.org <http://ebrary.ifpri.org/utils/getfile/collection/p15738coll2/id/31489/filename/31490.pdf> and Samuels, F. and Stavropoulou, M., *supra* note 124.

127 Oduro, R. *Beyond poverty reduction: Conditional cash transfers and citizenship in Ghana* (2015) 24(1) Intl J Social Welfare 27 and Tonguet Papucci A. *et al., supra* note 125.

128 Correa C and Gbery D., *Recommendations for Victim Reparations in Côte d'Ivoire: Responding to the Rights and Needs of Victims of the Most Serious Violations*, Abidjan, ICTJ, 2016. p. 7.

129 Economic Policy Research Institute, *The Social and Economic Impact of South Africa's Social Security System* (September 30, 2004) available at: allafrica.com <http://allafrica.com/download/resource/main/main/idatcs/00010352:3ca37b223f2ad1b0dc6479ccca726034.pdf>.

130 Davies, S. and Davey, J., A *Regional Multiplier Approach to Estimating the Impact of Cash Transfers on the Market: The Case of Cash Transfers in Rural Malawi* (2017) 26(1) Dev Policy Rev 96.

131 INURED, *supra* note 79.

132 OECD and INURED, *Interactions between public policy, migration and development in Haiti, Paris, OECD Publications, 2017; and World Bank. Haiti: Toward a New Narrative, Systematic Country Diagnostic* (2015) available at: worldbank.org <http://documents.worldbank.org/curated/en/642131467992805241/pdf/99448-SCD-Box393200B-PUBLIC-DOI-10-1596-K8422-PUB-DATE-9-8-15.pdf>.

133 INURED, *supra* note 79.

3. THE INDIVIDUAL APPROACH: RISKS

Although the participants were clear about the need to provide individual material assistance for the "hardest-hit victims" of the epidemic as part of a mixed approach, they were fully aware that the implementation of such a package would also entail non-negligible risks, particularly in an environment of limited resources. In addition to the financial, administrative and ethical obstacles – such as the creation of expectations – associated with the practical implementation of such a package, the risks identified can be divided into two main categories, namely, over-inclusion and under-inclusion of victims, and family and community conflicts.

3.1 Risks relating to victim identification

As regards the risks of over-inclusion and under-inclusion, the participants were categorical: the feasibility of an individual approach would depend on the UN's ability to implement a rigorous and fair system for identifying the beneficiaries of material assistance. In this regard, they believed that the principal risk of beneficiary identification was under-inclusion, as most victims do not appear to have official documents, such as medical certificates or death certificates.[134]

"We were not given a certificate… We did not bury him and they did not give us the body. … They told me that I didn't need to go back there and they didn't give me any paperwork."[135]

They emphasized their concern for the victims who were infected during the peak of the epidemic, when the health system and data collection system were overwhelmed in the face of the crisis. Most deaths at that time occurred outside of the formal health care facilities, and therefore might not have been formally documented:

"We did something very daring. We brought the body to Jérémie. When we arrived in Jérémie, we buried [our father] in our grandfather's grave. We didn't even go to the morgue."[136]

Reasons enumerated by participants regarding the difficulty in obtaining these documents included: the victims' inability to get to a health centre in time; the failure or refusal of health establishments to provide clear and precise documents as to the reason for their admission; the loss of official documentation; the subsequent closure of health care establishments; social inequities and disparities in access to health care;[137] the difficulties encountered by PSVs to obtain these documents retroactively.[138]

"Getting from Berly to Rivyè Fwad takes between 13 and 14 hours on foot. That's why many people died. They were not able to get to the hospital in time."[139]

134 *Ibid.*

135 *Ibid.*

136 *Ibid.*

137 Among the obstacles to health care access are the significant costs, the high ratio of patients for every health care professional and the distance between the population and the health centres (INURED, 2017).

138 *Ibid.*

139 *Ibid.*

Clearly, a number of the victims never asked for medical certificates because they didn't know such documents existed or what their eventual use might be. Some even said they were treated but were never told the diagnosis (suspected or confirmed) or given their test results, in cases where tests were done:

"When I got to the CTC at Terre Noire, the nurse took fecal and blood samples for me, but I never got my test results."[140]

Still other participants encountered financial barriers to obtaining medical certificates:

"My brother and my daughter contracted cholera at the same time. I was lucky because I was able to get their certificates in time. Now it's difficult to get a certificate because sometimes, you have to pay up to 250 gourdes for a records search, which the victims don't have."[141]

In addition to these problems of access, some documents held by the victims or by health centres were apparently destroyed, especially in the case of natural disasters:

"[The health centre] gave us the death certificate, but our house [lost its roof] in the disaster. We lost all our official documents. The house was completely exposed to the elements, it rained and the documents were washed away in the floods."[142]

Thus, the participants said that an approach based strictly on official documents would not work. In this regard, a fair and rigorous identification system should take these identification difficulties into consideration in order to avoid re-victimization.[143]

Conversely, while the participants acknowledged that some victims had official documents to support their claim, they also mentioned the very real risk of over-inclusion and fraud in the victim identification process, suggesting that the process should be based on certain objectively verifiable information. In their opinion, fraudulent claims might be made, in particular based on false testimony or forged documents.[144] Document forgery could quickly become a lucrative black-market activity and the participants emphasized their mistrust of certain elected officials who might facilitate the obtaining of such documents for their families and political supporters. They were also concerned about the participation of such elected officials in the management of assistance programs – whether for direct cash transfers, community economic development programs or even assistance in kind – recalling the scandals relating to the management of funds after the earthquake.[145]

"[They're] going to keep everything for themselves. And once their [term of office ends], they will sell the materials in their stores for high prices."[146]

140 Testimony of a cholera victim at la Plaine (Lamour et al., 2018).

141 Testimony of a mother and sister of cholera victims in Carrefour (Lamour et al., 2018).

142 INURED, *supra* note 79.

143 *Ibid.*

144 *Ibid.*

145 *Ibid.*

146 *Ibid.*

3.2 Risk of conflicts

According to the participants, an individual approach could trigger conflicts for a number of reasons. First, tensions might arise between neighbours or community members:

"If two people had cholera and one of them sees the other one receiving benefits, that could create a conflict between them."[147]

Family conflicts could also break out, especially when it comes to the determination of filiation or the fair allocation of the individual assistance among family members, particularly in contexts where family structures are complex:[148]

"if a man had two wives and the first one gets $10,000 with her child, and the other one gets nothing, there will be a conflict which could turn very ugly."[149]

Thus, although the participants ideally recommended that assistance be given to all family members in order to ensure a relatively fair distribution of funds, they recognized that proceeding in this manner could lead to certain difficulties during implementation. The diversity of family configurations made it difficult to formulate specific recommendations concerning the determination of a predetermined "family representative" who would receive the direct assistance and be responsible for distributing it fairly among the members.[150] In this regard the participants expressed a number of concerns regarding the identification of the representatives, particularly, the lack of transparency concerning the type or amount of assistance received; the difficulty in sharing the assistance fairly and equitably; and the possibility that family members who are not much involved in family life might take advantage and pass themselves off as close family members. While certain participants were concerned about distribution inequities arising from bad intentions, others mentioned that distribution inequities were more likely to arise where the needs were extreme in a particularly difficult financial situation (e.g., the lack of long-term employment).[151] However, it should be noted that if a representative has to be named, most of the participants said that the assistance should be paid to the person who supported (or currently supports) the family financially.[152] Certain participants said that the surviving spouse, if there is one, should receive the assistance and distribute it.

"If the father of a family dies and the mother is still alive, it's the mother who should receive the compensation and she will distribute it, given her spirit of sharing."[153]

147 *Ibid.*

148 *Ibid.*

149 *Ibid.*

150 The complex parentage relationships and family structures observed in Haiti (Lowenthal, 1980; Marcelin, 2012) make identifying legitimate beneficiaries complicated. For example, certain men are in polygamous relationships and sometimes have several biological children from more than one relationship. In this context, the determination of legitimate beneficiaries will be difficult and may lead to the exclusion of certain surviving women and children. Moreover, the diversity of family structures and the cases of formal and informal adoption may lead to the simultaneous existence of surviving parents and surviving caregivers in a single family (INURED, 2017).

151 *Ibid.*

152 This answer reflects certain cultural expectations that require the eldest members of the household (generally the eldest child) to support the family financially until the other children become independent. It should be noted, however, that the participants in the study shared stories about differences in the impact of the death on their families and on the resulting reassignment of responsibilities. In some cases, a widow may have assumed all the financial obligations for her children, whereas in other cases, the eldest son became responsible for the survival of his family members. In other situations, the brother of the deceased supported the widow and her children financially and looked after them. It also happened that although a child had lost only one parent, a member of the extended family, such as an aunt or a godparent looked after the child. (INURED, 2017).

153 *Ibid.*

4. THE COMMUNITY APPROACH: BENEFITS AND RISKS

4.1 Benefits

The participants said that cholera also had profound effects on communities and on the whole of Haitian society:

"Everyone in the community was a victim in some way, whether you lost someone, you were sick or you were living in an affected community. … Everyone is at risk because we don't have good roads, access to water and sanitation."[154]

Apart from the water which was no longer drinkable in a number of communities, the participants also mentioned that the epidemic had a significant impact on Haitian society, contributing to a breakdown in the social fabric.[155] Indeed, several months after the start of the epidemic, the public had still not been informed about the actual source of the outbreak and information about the way in which cholera was spread was very limited. This generalized lack of understanding gave rise to a climate of fear which further marginalized certain PSVs, increased social inequalities and further contributed to a generalized feeling of insecurity.[156] For example, in the months following the start of the epidemic, at least 45 people, especially healers from minority religious groups such as Vodou practitioners, were attacked by frightened members of their community, accused of witchcraft and of having introduced the disease into the community.[157] Moreover, the economic consequences of cholera in Haiti directly affected many farmers and merchants, as local products were boycotted by the public, who were afraid that they were contaminated by cholera.[158]

In addition, the fear of contracting cholera from infected corpses also changed cultural traditions associated with death, funerals (e.g., traditional wakes[159]) and burials in certain regions. The same fear caused public hospitals and private morgues to stop admitting the bodies of people who had died from the disease[160], even forcing the authorities in certain localities to require the corpses of victims to be placed in plastic bags and thrown into mass graves, although this was contrary to Haitian custom.[161]

154 *Ibid.*

155 *Ibid.*

156 *Ibid.*

157 Le Monde *Choléra en Haïti: les autorités inquiètes de lynchages à mort* (2010) available at: lemonde.fr <https://www.lemonde.fr/ameriques/article/2010/12/23/cholera-en-haiti-les-autorites-inquietes-de-lynchages-a-mort_1456914_3222.html>.

158 CNSA, *Haïti: Perspectives sur la sécurité alimentaire, janvier à juin 2012* (2012) available at: reliefweb.int <https://reliefweb.int/sites/reliefweb.int/files/resources/Rapport%20complet_69.pdf>, p. 7.

159 The traditional wake is a ceremony during which the deceased's family members wash and keep a vigil over the body of the deceased person until they are buried. Generally, the community also participates to show its moral support for the victim's family. These ceremonies stopped being held in certain regions due to proximity with the deceased and the associated risks of transmission (Lamour et al., 2018).

160 Sérant, Claude Bernard, *Les morgues refusent les cadavres contaminés,* Le Nouvelliste (2010) available at: lenouvelliste.com <https://lenouvelliste.com/article/85875/les-morgues-refusent-les-cadavres-contamines>.

161 Le Monde *Grande Saline: Les victimes du choléra interdites de funérailles* (2010) available at: lemonde.fr <https://www.haitilibre.com/article-1522-haiti-grande-saline-les-victimes-du-cholera-interdites-de-funerailles.html>.

The participants thus acknowledged that unconditional cash transfers alone cannot make up for the profound impact of the epidemic on whole communities and the persistent risks of contagion that they continue to face. In this regard, all the participants agreed that a community approach[162] was required as part of any material assistance and support package:

"If I were the UN, the first thing I would do would be to appeal to people's consciences. We had no experience of this disease and most people were not properly buried. Cholera thus continues to be a threat to the community."[163]

They also emphasized that a collective approach would reach a larger number of victims and would make the package simpler and easier to implement. Some of them also said that, when combined with an individual approach, the collective approach would mitigate certain risks of conflict, particularly the risks of family conflicts previously mentioned, which might be associated with cash transfers.[164]

4.2 Drawbacks and risks

However, the participants also drew attention to a number of drawbacks to the community approach, particularly if it is not implemented in conjunction with an individual approach. They believe that a strictly community approach would not reflect the needs and priorities of the "hardest-hit victims," as it would fail to recognize the personal nature of the suffering experienced and would be unable to remedy the variety of harms. In their opinion, a strictly community approach would exacerbate inequalities and result in the re-victimization of PSVs in addition to giving rise to fraud, corruption and mismanagement and having a limited long-term impact on the "hardest-hit victims."[165]

According to the participants it would be fair and necessary to provide the "hardest-hit victims" with complementary individual assistance, because a community approach would not be sufficient to respond to the private and personal consequences[166] of the epidemic on victims, the economic harm and the disparities in the experiences of suffering as described above.[167] Adopting a strictly community approach could have the effect of fostering resentment among victims and thereby increase the risks of community and family conflicts. In fact, it has been shown in other contexts that tensions may emerge when, as a result of a lack of differentiation in the aid received, the extent of the harm and its long-term impact on certain victims is not reflected in assistance programs.[168] A strictly community approach would not be able to account for the specific assistance that the victims need and would not contribute to their financial independence.[169]

162 The priorities most often mentioned as part of a package to optimize collective benefits were: increasing access to health care by building health centres; training health officers; a large scale plan to manage victims' mental health; correcting deficiencies in the infrastructures that make people vulnerable to disease; implementing or financing educational initiatives; creating economic activities that allow people to meet their longer term needs. Calling on experts able to study the long-term effects of cholera on survivors and creating centres to care for street children (abandoned or orphaned children) were also discussed (INURED, 2017).

163 *Ibid.*

164 *Ibid.*

165 INURED, *supra note 79.*

166 That has also been confirmed in other contexts: "collective reparation in the form of development programs and projects may meet with some resistance from victims, as they do not always reflect the private and personal nature of their suffering" (LWBC, *supra note 61, p. 43.)*

167 INURED, *supra note 79.*

168 Correa C. and Gbery D., *supra note 128.*

169 *Ibid.*

The participants believe that a strictly community approach could exacerbate social inequalities and have particularly harmful repercussions for PSVs. It has already been shown that an assistance package must absolutely take into consideration the concerns of the victims about the impact of the epidemic on their means of subsistence.[170] Although most of the needs identified by the participants related to financial assistance, housing and health care, the participants also mentioned that the specific needs and priorities of the "hardest-hit victims" vary considerably from one person to another based on the disparities previously mentioned. Since a strictly community approach implemented in isolation cannot realistically provide a customized solution for every situation, it could exacerbate existing inequalities. In fact, the people most affected (especially PSVs) often face barriers that prevent them from accessing programs, which creates a considerable risk of re-victimization, as was the case with the assistance provided after the earthquake.[171] The choice of approach and the appropriate measures should thus be based "on an examination of their local impact, in particular in order to avoid creating or recreating stigmatization, discrimination or injustice."[172]

In addition, the participants fear that there would be virtually no spin-off effects for the victims themselves from a collective assistance package.[173] Such a strategy may reach a large number of people in absolute terms, but it does not take into account the specific suffering of the victims, including the impact of the disease on close family members of the deceased and on survivors, or create long-term effects that would benefit them directly.[174] Moreover, in collective programs one must be particularly vigilant to ensure that the measures are not "confused with humanitarian aid or development projects which the communities are entitled to independently. They must instead be designed as a response to violations and harm experienced by the victims."[175]

If I am the victim, I should be the one to benefit. Sometimes they begin building a school or a hospital and those who were not victims are the ones who benefit, but I, who was a victim, do not receive anything. These initiatives are always carried out as community projects, but we don't really benefit."[176]

Lastly, one of the challenges most often mentioned by the participants concerns the risk of fraud and mismanagement. The participants said that these community initiatives did not generally result in significant long-term changes (as a number of post-earthquake aid programs have shown[177]) because they were often ill adapted, mismanaged or simply abandoned after a few years. There also seems to be a generalized mistrust of State and local institutions and authorities: the participants expressed significant concerns about the risks of mismanagement – even corruption – associated with community initiatives.[178] In fact, the concern is a legitimate one, as Haiti is ranked 161 out of 180 countries for corruption in 2018, with a score of 20 on Transparency International's scale.[179]

170 For the participants, the family's loss of a breadwinner or other financial support was considered to be of the utmost importance in designing a package of material assistance. A young Haitian woman worried about her mother and her seven siblings, who lost their father and an older brother. She herself was obliged to abandon her studies and she is afraid she will not be able to attend university again in the future. Another participant with several children expressed her fear about not being able to support her family after the death of her husband. A participant from Pétion-Ville described how he had become the main provider of care for his brother's widow and child (INURED, 2017).

171 For example, in a community program providing scholarships for victims, the participants clearly indicated that even if tuition was completely free, other related expenses could prevent a child who received a scholarship from taking full advantage of it, such as the cost of uniforms, school supplies, transport or meals (INURED, 2017).

172 LWBC, *supra note 61, p. 41.*

173 Correa, C., *supra note 70, p. 24.*

174 *Ibid.*

175 LWBC, *supra note 61, p. 43.*

176 INURED, *supra note 79.*

177 This is notably the case with hospitals or health centres, schools or sanitation systems whose design does not take into account the local reality, whose management is no longer guaranteed after a certain time, or whose required routine maintenance is not assured (INURED, 2017).

178 *Ibid.*

179 Transparency International. *Corruption Perceptions Index 2018: Haiti (2018) available at: transparency.org <https://www.transparency.org/country/HTI#>.*

Thus, the implementation of a strictly collective approach would likely be ineffective and create a strong feeling of bitterness and lack of legitimacy among certain victims, thereby encouraging the emergence of conflicts.[180]

It follows that the individual and community approaches are complementary and reinforce each other: alone, neither would be sufficient to meet the needs of the victims, particularly the "hardest-hit victims", and still be adapted to the realities of the communities. Although there are differences in the preferences of different communities, the participants recognized the strengths and weaknesses of each approach and generally favoured the implementation of a mixed approach. Such a strategy includes both direct or individual material assistance for the victims who suffered the most, and community programs that would address some of the devastating effects of the epidemic on whole communities or on a larger scale. Thus, the benefits of each approach can be optimized and their respective risks balanced out.[181]

180 *Ibid.*

181 *Ibid.*

PART 3
THE FEASIBILITY OF AN INDIVIDUAL APPROACH

Having discussed the victims' perspectives regarding their needs, expectations and priorities and the general risks and benefits of the two components, we now turn to an evaluation of the feasibility of an individual approach as part of a mixed package of material assistance and support.

Although civil law jurisdictions generally provide specific mechanisms (usually through judicial remedies) to decide on each claim based on an individualized assessment of the harm suffered,[182] this way of proceeding is not customarily advocated in large scale programs where documentation is limited (as in the current case), even for an individual assistance approach. In such circumstances, a strictly legal process would be a "waste of time and resources" in addition to hurting "those who do not have evidence … of other forms of harm, who, in many cases, will be the least educated and the poorest."[183] So, although more inclusive and fairer in theory, the implementation of such a process raises issues of accessibility for the victims, and re-victimization and exclusion of PSVs. Moreover, such a process would be bureaucratic and administratively complex: not only is the mobilization of massive human, material and financial resources rarely possible in this type of situation, but the associated operating costs are likely to substantially exceed the potential social and economic benefits for the victims themselves.[184]

Since these are common obstacles in similar contexts, the lessons learned from comparable cases can teach us how to evaluate the relative feasibility of implementing an individual approach in the current case and what kind of assistance package would be suitable. Thus, in order to ensure that certain criteria are satisfied (such as inclusion, equity and accessibility), despite financial and administrative constraints, in similar contexts, individual approaches have often been implemented through administrative programs of material and financial assistance or programs of administrative reparations. These programs, which are more effective, more accessible and less expensive than a true judicial process, aim at "strengthening accessibility [for victims], lowering the burden of evidence … and covering broad categories of victims."[185] In most cases, the effectiveness of individualized programs was jeopardized by planning deficiencies "such as insufficient funding, ineffective dissemination strategies, lack of training of agents responsible for taking statements, and inadequate design of data gathering and storage systems."[186]

182 Correa, C., *supra* note 70, p. 12.

183 *Ibid,* p. 6.

184 *Ibid,* p. 16.

185 *Ibid,* p. 10.

186 *Ibid,* p. 24.

Generally, the lessons drawn from these similar contexts reveal three main elements that ensure a degree of effectiveness of the process: a) adequate planning of the package, b) sufficient financial and administrative resources to implement the package; and c) operating methods that foster accessibility, equity and representativity of the victims. In fact, the most effective and best adapted packages are those that were designed based on clear, specific and precise objectives based on the victims' needs and priorities as expressed by them in adequate consultations. The best performances were obtained using means of optimizing the available resources, in particular by using a simplified system for processing and reviewing claims characterized by administrative simplicity.[187]

These comparative examples tend to show that, though necessarily imperfect, the implementation of an individualized approach to material assistance by means of an administrative program is possible in practice and may be adapted to the present case, provided that it strikes a balance between: the demands of the administrative and financial constraints; the informational constraints; the needs and priorities of cholera victims in Haiti; the UN's commitments to the victims; and the international human rights standards. In order to design a model that takes into account all of these constraints, we propose a mixed approach, that limits the individual component strictly to the conditions that justify its existence, by addressing the specific needs and priorities of the victims most severely and directly affected that would not be fully and adequately addressed by community programs.

In order to define clear and precise specific objectives that will allow careful design and planning of a process based on both realistic and fair operating criteria, we must 1) determine the potential beneficiaries of the package; 2) evaluate whether and how these beneficiaries can be identified through the information systems set up by State and non-State actors; 3) propose a technically appropriate model to decide the claims properly.

1. THE DEFINITION OF A CHOLERA VICTIM AND ITS RELEVANCE IN DETERMINING WHO ARE THE BENEFICIARIES

To be effective and appropriate, the proposed process must build upon clear and precise objectives for the different classes of victims and harms to be addressed; and they must be at once rigorous, feasible, accessible and fair. Consequently, we must first define who is a victim and determine the applicability of that definition in this instance. Then there are medical and practical considerations that must be examined to determine the status of the cholera victim.

1.1 The definition of a cholera victim and its applicability in this instance

In order to understand who can be considered a victim and determine whether the definition applies in this instance, we should note that, according to the UN General Assembly, victims are persons who "individually or collectively suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts or omissions that constitute gross violations of international human rights law, or serious violations of international humanitarian law."[188] Human rights law therefore recognizes that victims may be direct or indirect,[189] that the harm can be physical, emotional or economic and that their suffering can be both individual and collective.

187 *Ibid.*

188 *Basic Principles and Guidelines on the Right to a Remedy and Reparation, supra note 56, Princ. V(8).*

189 In the present case, a direct victim is a person who suffered harm as a result of cholera (e.g., persons who were infected with the disease), whereas indirect victims are those who suffered harm as a result of harm to the direct victim (e.g., the close relatives of victims who died of cholera).

Of course, it is essential to keep this definition in mind in order to design a program that is as complete and well-adapted as possible. However, given the practical constraints, it would be unrealistic to design an individual approach on the basis of such a broad definition and to attempt to remedy all the damage suffered.[190] In the context of the Haiti cholera epidemic and given the effects on Haitian society described above, it is very likely that many Haitians sustained some harm in connection with the cholera epidemic.[191] Therefore, including all the victims, i.e., any person who directly or indirectly suffered physical, financial or emotional harm as a result of the cholera epidemic, would involve deciding individually on far too many cases and a wide range of harms.

Recognizing that such a broad approach would be neither practical nor possible to implement in the present context, the UN has already stated that generally the beneficiaries who should be given priority in the second phase of the *New Approach* are "those Haitians most directly affected by cholera, centred on the victims and their families and communities."[192] Since the processes that worked best in other contexts are those where the nationals were most consulted and involved in the definition, implementation and assessment of the approaches in question,[193] it seems logical that the beneficiaries of the package of material assistance and support would be determined based on the perspectives expressed by the victims who were consulted on the matter, thus giving priority to those they themselves identified as the "hardest-hit victims of cholera".

So, respecting the methods that have proved most effective in other circumstances and the UN's commitment to take into consideration the perspectives of the victims (see PART 2: Victims' perspectives benefits and risks of the individual and collective approaches), the immediate family members of individuals who died from cholera – with particular emphasis on children and young adults and families who suffered serious economic consequences – should be considered to be priority beneficiaries of the package. Survivors of the disease, especially those who continue to suffer from significant consequences could also be considered as a second class of beneficiaries, although with a lower priority.[194]

That does not mean, however, that the other classes of victims should be entirely excluded from the process, but that the victims acknowledge the difficulties associated with an individual approach and are aware that other types of harm may be easier to address effectively through other initiatives (such as community programs) in a broader mixed approach.[195]

1.2 Determining the status of cholera victim and its applicability in this instance: medical and practical considerations

To define the status of cholera victim in this instance and identify potential beneficiaries, there are certain medical and practical considerations that apply to establish the precise criteria for who can be considered a cholera survivor or an immediate family member of a person who died from the disease. These considerations must then be analyzed in light of the specific cholera situation in Haiti in order to develop a potential ranking of the victims to be identified.

190 Correa, C., *supra* note 70, p. 15.

191 *Ibid.*

192 UN Secretary-General, *supra* note 21, p. 4.

193 Correa, C., *supra* note 70, p. 25.

194 INURED, *supra* note 79.

195 For example, farmers whose income declined as a result of the boycott of local products are a group of victims who were particularly affected by the epidemic economically. Although it would be too difficult to examine each individual case by assessing the value of the harvests lost, it might be appropriate to introduce specific regional or local programs so that farmers can recover some of their losses and regain some financial independence. Similar programs could also be introduced for communities where vodou practitioners were lynched, for example.

a) Cholera diagnosis: general medical considerations

The WHO describes cholera, which is caused by the *Vibrio cholerae bacterium, as "an extremely virulent disease that can cause severe acute watery diarrhoea" in symptomatic individuals, who account for about 25% of cases. Cholera can "cause death within hours of onset if no treatment is administered," with the most severe cases showing severe dehydration, the symptoms being caused by "loss of electrolytes, vomiting due to acidosis and leg cramps caused by hypokalemia."*[196]

From a technical standpoint, while it is true that certain less severe cases may be incorrectly diagnosed as other types of acute diarrhoea (and vice versa) due to the non-specific nature of the symptoms, the risk is not as great when the symptoms[197] are sufficiently severe to warrant medical attention (about 10 to 20% of cases) or even result in death. It remains, however, that although the symptoms of cholera are distinctive, they are not unique.[198] As well, the bacterium responsible for cholera is only present in the patient's feces.[199] As a result, from a medical perspective, cholera can only be confirmed with absolute certainty by "identifying *V. cholerae in stool samples."*[200]

b) General practical considerations

Although the diagnosis or attribution of death to cholera with scientific certainty requires a fecal culture, in practice these cultures are often not done. In fact, "[t]he definition used by the World Health Organization recognizes that most health facilities will not be able to carry out fecal cultures and will have to make a diagnosis based on clinical signs and symptoms."[201] Thus, in practice, a cholera case "generally refers to a person who has acute watery diarrhea rather than a person from whom the bacterium can be isolated."[202] In terms of specific protocols, "At the beginning of the outbreak, laboratory investigations are performed in a group of patients presenting with compatible clinical signs of cholera, to confirm whether *Vibrio cholerae is the causative pathogen …"*[203] Then, "once the cholera outbreak has been bacteriologically confirmed, diagnosis of subsequent cases relies on clinical case definition and clinical assessment only. A sudden onset of severe watery diarrhoea during a cholera epidemic is highly predictive of cholera."[204]

According to the WHO, "[i]n areas where a cholera outbreak is [officially identified and] declared,[205] a suspected case is any person presenting with or dying from acute watery diarrhoea [three or more loose or watery, non bloody stools within a 24-hour period."[206]

In the case of an epidemic or in the absence of medical certainty, the severity of the symptoms (particularly dehydration) and the existence of an outbreak in the area (sudden increase in the number of cases) are the primary indicators of the probability that a person presenting with

196 MSPP, *Manuel de formation pour la lutte contre le choléra en Haïti: un cours abrégé pour les fournisseurs de soins de santé* (2011), available at: mspp.gouv.ht <https://mspp.gouv.ht/site/downloads/Manuel%20de%20formation%20haiti%20cholera.pdf>, p. 10.

197 Indeed, the symptoms of cholera may be distinguished from other acute diarrhoeas of viral, parasitical or drug origins, as well as those associated with bacteria that penetrate the intestinal walls (which trigger a "dysenteric" syndrome, i.e., bloody mucus diarrhoea accompanied by fever). *Vibrio cholerae* belongs to the class of enterotoxigenic bacteria, which act by adhering to the intestinal mucus and secrete a pathogenic toxin in the small intestine, triggering a "choleriform" syndrome, i.e., abundant and acute watery diarrhoea, sometimes called rice water stool, generally without any accompanying fever. (Institute of Tropical Medicine, Université de Bordeaux, 2018).

198 Cholera is not the only microbe that can cause a choleriform syndrome and some ailments present a mixed syndrome (both choleriform and dysenteric).

199 Interview of Renaud Piarroux, *supra note 80*.

200 WHO, *Cholera (2011) available at:* <https://www.who.int/news-room/fact-sheets/detail/cholera>.

201 *Stop cholera, Glossary of terms related to cholera and cholera vaccine programs (2016),* available at: <https://www.stopcholera.org/sites/cholera/files/glossary_of_terms_for_cholera_and_cholera_vaccine_programs.pdf>, p. 8.

202 *Ibid*

203 MSF, *Management of a cholera epidemic (2017), available at:* https://samumsf.org/sites/default/files/2018-10/Management%20of%20a%20Cholera%20Epidemic.pdf, p. 17.

204 *Ibid.*

205 It should be noted that, according to the WHO, even in an area where a cholera epidemic has not been declared, "a suspected case is any patient aged ≥ 2 years who has acute watery diarrhoea and severe dehydration or died from acute watery diarrhoea."(WHO, 2018, p. 5).

206 WHO, *supra note 77, p. 5.*

clinical signs of cholera is actually infected.[207] In fact, according to Dr. Renaud Piarroux, the approximate percentage of positive cultures tested during outbreaks in Haiti exceeded 80%, whereas it was approximately 50% at other times.[208] Thus, apart from cholera cases that were formally confirmed or rejected following fecal cultures, the probability of each specific case involving a patient 5 years of age or older depends on matching the clinical signs and typical symptoms of the disease (See Appendix 4: Classification of Types of Cholera Cases).

As for deaths, from a strictly medical and scientific perspective, it is the symptoms of cholera (diarrhoea and severe vomiting) and not the bacterium itself that, untreated, may lead to complications (severe dehydration, electrolytic imbalance, inhalation pneumonia, etc.) which lead to the patient's death.[209] However, from an epidemiological and practical standpoint, it is generally acknowledged that, during an epidemic or outbreak, a suspected, probable or confirmed case of cholera which led to the death of the patient within about a week following the symptoms being reported is a death attributable to cholera. In fact, in the case of patients 5 years of age or older, any "death caused by severe acute watery diarrhoea" is assumed to be a cholera death.[210]

From a medical perspective, severe acute diarrhoeas (i.e., requiring medical treatment) in children under 5 (and even more so in those aged under 2) should be distinguished, as they may be attributable to other ailments, such as rotavirus.[211] Nonetheless, although rotavirus remains the most common cause of severe fatal diarrhoea among infants worldwide, the probability that a child under age 5 presenting with watery diarrhoea is actually suffering from cholera is very great during an outbreak.[212] That is why, from an epidemiological standpoint, cases of "acute watery diarrhoea and severe dehydration" in patients aged between 2 and 4 and those "dying from acute watery diarrhoea" are included as cholera cases, provided at least two suspected cases have been detected "from the same area within one week of one another".[213]

Although deciding these cases may be more complex than for patients age 5 or older, certain elements do allow a more accurate assessment of the probability: for example, a child who has been in direct contact with a suspected or confirmed case of cholera or from a locality where there is an outbreak. Another indicator could be the fact that the child received a rotavirus vaccine (or if a vaccination campaign was conducted in the area where the child lives before symptoms were reported), thereby reducing the probability that acute diarrhoea is attributable to rotavirus.[214] In this regard, according to the official MSPP data, it is estimated that cholera cases among children under 5 represent a relatively small number of the cholera victims recorded in Haiti, namely about 14%.[215]

c) Considerations applicable to the Haitian case

As observed in other countries (especially where financial and human resources are limited), in Haiti, very few fecal cultures were performed, particularly at the start of the epidemic. As a result, the percentage of patients who were formally diagnosed with cholera (confirmed cases) was minuscule compared with the number of people who potentially contracted the

207 *Ibid.*

208 *Ibid.*

209 Interview of Renaud Piarroux, *supra* note 80.

210 WHO, *supra* note 77, p. 5.

211 In fact, although cholera was isolated in about 70% of cases of acute diarrhoea (without considering whether the stools were watery or not) in individuals 5 years of age or older during the epidemic, it was only isolated in about 49% of cases of children between the ages of 2 and 4 and 13% of children under the age of 2 (Steenland M. et al.. 2013).

212 Interview of Renaud Piarroux, *supra* note 80.

213 WHO, *supra* note 77, p. 5.

214 It should be noted that starting in 2013, various rotavirus vaccination programs were conducted in certain regions of Haiti, thereby considerably reducing the number of cases of severe acute diarrhoea in children caused by rotavirus (PATH, 2013).

215 Steenland, M. et al., *Laboratory-Confirmed Cholera and Rotavirus among Patients with Acute Diarrhea in Four Hospitals in Haiti,* 2012-2013" (2013) 89 (4) Am J Tropical Medicine & Hygiene 641.

disease. In fact, the number of people for whom a fecal culture was performed is estimated at about 10,000, or less than 1.25% of the total number of people infected according to the MSPP's data.[216] Most of the diagnoses were thus made based solely on symptoms and the fact that they matched official technical definitions.[217]

Nationally, although the definitions of a "suspected case" or a "probable case" may have varied slightly from one treating institution to another between 2010 and 2016, they all met the minimum threshold of *the MSPP definition (namely, any person presenting with acute diarrhoea, with or without vomiting, during an outbreak). It should be noted that most of the third-party treating institutions only identified a patient as a suspected case if they also observed watery or rice water stools*.[218] However, from a medical and epidemiological standpoint, independently of the definition used and despite the lack of fecal cultures, patients admitted to a health centre as "suspected cases" or otherwise presenting with clinical signs of cholera between 2010 and 2013 (i.e., during the epidemiological peak of the disease nationally), had almost always contracted the disease.[219] This is even truer of the period from 2010 to 2011, in which the highest incidence and the largest number of victims since the start of the epidemic occurred. Given the considerable decline in the number of cases nationally (the disease had even vanished from certain areas) starting in 2014, the general probability that a patient presenting with clinical signs of the disease had actually contracted cholera declined gradually,[220] making circumstantial data about outbreaks more relevant to decide cases during that period.[221]

Starting in January 2017, new criteria for suspected cases were institutionalized in order to reflect the new national epidemiological situation. These new criteria included an absence of fever or of bloody stools and the presence of dehydration as an integral part of the clinical signs to be observed.[222] Since this change, fecal cultures also became mandatory for diagnosis as they also have significant benefits in terms of epidemiological monitoring due to the fact that the incidence has greatly decreased.[223]

Thus, from a medical and epidemiological standpoint, this analysis reveals that a patient admitted to a health centre as a "suspected case" or presenting clinical signs of the disease (as determined by the technical definitions specific to each period) during the cholera epidemic in Haiti is probably a cholera case, with the specific probability declining gradually from 2014 onward. As for deaths, they may be attributed to cholera if they occur about one week following reporting of the symptoms associated with a suspected case.

It is important to note that although these general findings per period are sufficient to decide claims in the great majority of cases, exceptionally, the following information may be used as an indicator: clinical observations (e.g., the death of the patient or the severity of the symptoms more broadly); circumstantial epidemiological data (including direct contact with other cases or the occurrence of a local outbreak at the time the symptoms were reported).[224] These additional considerations may be useful in more complex cases involving children under the age of 5, for whom prior vaccination against rotavirus may also be considered an indicator.

216 Interview of Renaud Piarroux, *supra* note 80.

217 *Ibid.*

218 For example, MSF Hollande considered that there had to be at least 3 bouts of watery diarrhoea within a 24-hour period to consider a case as a suspected case (MSF Hollande, 2017).

219 Interview of Renaud Piarroux, *supra* note 80.

220 *Ibid.*

221 Although a summary portrait of the general probability by period can be constructed based on the national epidemiological data, the data relating to occasional outbreaks in a more restricted geographic area – for example within a department, commune or locality (communal section, town, hamlet) – are more precise and provide more reliable indicators for evaluating the specific probability of each case. This data could exceptionally help to decide more complex cases.

222 Interview of Thierry François by Sabine Lamour (May 2018) Jérémie.

223 Interview of Renaud Piarroux, *supra* note 80.

224 Interview of Renaud Piarroux, *supra* note 80.

2. IDENTIFICATION OF VICTIMS AND VERIFICATION OF INFORMATION

Considering that the medical and practical considerations which offer clarifications on how victim status could be established in this instance, it is now appropriate to consider how victims might be identified by setting up a rigorous and efficient system of identification and information verification.[225] To this end, it is necessary to determine what information is available and useful in carrying out this exercise, where it can be found and who manages it. First, an analysis of the current state of the documentation existing within the epidemiological monitoring and patient care systems will be presented, notably to assess its reliability and extent. Secondly, community resources will be analyzed to assess how they might be mobilized to fill gaps in the formal system, notably to verify or complete the official data.

2.1 Haiti's health care system and the state of the existing documentation

The documentation held in the formal system can help to identify victims and verify their information. The Haitian health care system is composed of numerous institutions and facilities that intervened at various levels during the cholera epidemic and these institutions hold relevant information about the victims. Headed by the MSPP, the relevant agencies can be divided into two categories: prevention facilities and patient care facilities. Prevention facilities include the pre-existing epidemiological surveillance facilities operating under the aegis of the Directorate of Epidemiology, Laboratories and Research (DELR), and these contributed directly to the data gathering on the epidemic nationwide. As for patient care, the pre-existing health care structures were mobilized and other entities were specially developed to respond to the cholera epidemic.

2.1.1 The surveillance and alert-response system

A) MSPP SENTINEL SITES

As a pre-existing national data collection mechanism, the MSPP's epidemiological surveillance system might constitute an essential source of information to identify certain cholera victims or to verify their information. This epidemiological surveillance mechanism already had sentinel sites, i.e., alert and surveillance systems to allow it to monitor the evolution of certain contagious diseases and to alert the public in the event of risks to public health. These pre-existing sites were mobilized and strengthened as part of the epidemiological surveillance of cholera, increasing from 54 to 106 sites between October 2010 and December 2012.[226]

As part of this network of sentinel sites, epidemiologists assigned to each local health care facility submitted epidemiological data on cholera for the geographical zone and the applicable time period to Epidemiological Surveillance Officers (ESOs). The ESOs, who were responsible for reviewing the consultation records and compiling the data, then reported unusual cases to the department's health directorate on a daily basis via a *Monitoring, Evaluation and Surveillance Interface* (MESI).[227] The data was then confirmed by an epidemiologist in the department, who after investigating with the officer in charge of the zone concerned, then submitted the data to the DELR, which compiled the data nationally and analyzed it for statistical purposes.[228]

While the field interviews could not confirm the availability of individualized data on the victims, it is probable that such data are to be found at some of the local sentinel sites,

225 INURED, *supra* note 79.

226 MSPP, *Plan stratégique pour le renforcement de la surveillance épidémiologique en Haïti*, 2013-2018 (2013) available at: mspp.gouv.ht <https://www.mspp.gouv.ht/site/downloads/Plan%20strategique%20DELR%202013-2018.pdf>, p. 17.

227 Lamour et al., *supra* note 108.

228 *Ibid.*

particularly the informal sites managed by third-party organizations, which may have had better methods of compiling and storing information. Such data might be traceable through the ESOs, who in the course of their review and compilation work, would have had access to such information at the local level.[229]

However, while the ESOs were relatively well trained to perform their duties, they had limited resources to do the work effectively and consistently. Although the number of sentinel sites increased considerably after the start of the epidemic, the fact is that in 2012 the system covered no more than 10% of the national territory and the sites were not uniformly distributed across the country, leaving certain areas underrepresented.[230] Consequently, it is probable that information that concerns more than 90% of the territory comes from other underqualified institutions, for example unofficial sentinel sites whose level of training and available resources varied from one institution to the next.

B) TEAMS DEPLOYED IN THE FIELD

As part of the epidemiological surveillance and alert-response system, teams from WHO and the Pan American Health Organization (PAHO) were sent into the field to provide technical and logistical support to the public health authorities and develop an appropriate response based on the needs and the situation.[231] Initially assigned to the departments with the greatest number of victims, (Nord, Artibonite, Centre and Ouest), these teams were subsequently deployed across the country. Starting in 2014, the MSPP gradually set up its own field teams – the mobile rapid response teams (EMIRA), which worked in collaboration with the PAHO, WHO, and UNICEF teams, as well as other independent organizations. Numbering between 32 and 88, depending on the period, all these teams pooled their efforts, participating in the search and chlorination of contaminated water sources, in disease prevention (particularly through awareness campaigns and the promotion of good hygiene) as well as treatment of the cholera (decontaminating infected households, treating patients and actively tracing cholera cases).[232]

They focused their interventions on at-risk areas and areas where an outbreak had been confirmed, in order to prevent new infections and limit the spread of the disease. Although their work was not specifically to compile personal information about victims, our interviewers learned that some of these teams did record in writing the names, addresses and telephone numbers of the people who benefited from their services.[233]

C) THE POTENTIAL ROLE OF THE SURVEILLANCE AND ALERT-RESPONSE SYSTEM IN IDENTIFYING VICTIMS AND VERIFYING THEIR INFORMATION

The network of sentinel sites is a useful source for identifying victims, but its scope is limited and its analysis of epidemiological data is neither consistent nor exhaustive.[234] Its usefulness as part of such a mechanism would therefore vary from one locality to another.[235] Consequently, the sentinel sites could be used as part of a complementary victim identification system in certain specific geographic zones or for the subsequent verification of information in more complex cases. Thus, by obtaining the MSPP's authorization to contact the sentinel sites, it would be possible to obtain a broad national picture of the specific localities where information is sufficiently detailed to be used for such purposes.

229 *Ibid.*

230 MSPP, *supra* note 226, p. 17.

231 Interview of Renaud Piarroux, *supra* note 79.

232 *Ibid.*

233 *Ibid.*

234 Lamour et al., *supra* note 108.

235 These conclusions are based on interviews with an administrator at the DELR, a supervisor of epidemiological surveillance in Grande-Anse and a hospital administrator in the commune of Anse d'Hainault (Lamour et al., 2018).

Meanwhile the PAHO, WHO, MSPP (EMIRA) and UNICEF field teams and some independent organizations appear to be an avenue worth exploring, particularly to identify certain victims who did not visit a health centre (particularly those infected in 2013 and after). Moreover, since these teams were under the direction of or worked in close partnership with the MSPP, the MSPP could facilitate access to the information in their possession. The lists could be consolidated in collaboration with members of the MSPP, WHO and PAHO, particularly those who were sent into the field. Given their work in close proximity to the sick and their knowledge of the areas where they were deployed, these teams could be remobilized to help identify those who contracted and/or died of cholera in the community and to verify information in these zones.[236]

2.1.2 Cholera patient care system

To make up for the deficiencies of the surveillance and alert-response systems, cholera patient care facilities must also be called into service for victim identification.

In order to determine what information these structures may be able to contribute to this exercise, it is important to understand how the Haitian health care system is organized.

The Haitian health care system forms a pyramid consisting of three levels of care (See Appendix 5: Organization of the Haitian Health Care System). At the local level (the primary level), the health care services are delivered by 58 communal health units (CHUs). Providing emergency and community-based health services, these units consist of 795 1st echelon health facilities (SSPEs) staffed by general medical personnel,[237] community health workers[238] and ambulatory personnel[239] who travel to remote areas or areas that are difficult to access.[240] These facilities may be doctors' offices, dispensaries, health centres without beds (CSL) and with beds (CAL). The most serious cases – for example those that cannot be treated by the SSPEs – may be directed to one of the 45 community referral hospitals (HCRs) that have medical[241] and paramedical[242] staff who are more specialized.[243] In more complex cases requiring specialized care, patients may be referred to one of the ten departmental hospitals (secondary level) or to the national level (third level) at the State University Hospital of Haiti (HUEH) or one of the specialized national centres.[244]

The pre-existing structures of the health care system, namely 908 facilities that provide assistance and care, have long been insufficient to meet the basic needs of the population.[245] Information gathered in the field indicates that the entire pre-existing health care system had to be mobilized to varying degrees to provide direct care to cholera patients. This was true particularly at the beginning of the epidemic, when the health care system was overwhelmed by the enormous need for cholera patient care, forcing all structures to intervene regardless of their degree of specialization.[246]

New local patient care facilities had to be set up to make up for the inadequacy of the pre-existing facilities. CTCs, whether or not associated with pre-existing health centres, thus

236 Lamour et al., *supra* note 108.

237 General medical staff in the SSPEs include: general practitioners, nurses, nursing assistants, etc. (MSPP, 2006, p. 114-116).

238 Community actors in the SSPES include: health officers, birth attendants, traditional healers, etc. (MSPP, 2006, p. 116-117).

239 Roving personnel in the SSPEs include nurses and health officers (MSPP, 2006, p. 117).

240 MSPP, *Représentation du système de santé : Le paquet minimum de services, cadre conceptuel* (2006) available at: mspp.gouv.ht <https://www.mspp.gouv.ht/site/downloads/Paquet_minimum_de_services_1er%20niveau.pdf)>, p. 117.

241 Specialized medical staff at the HCRs include: specialist physicians, surgeons, anesthetists, pharmacists, etc. (MSPP, 2006, p. 118-119).

242 Specialized paramedical staff at the HCRs include: midwives, specialized nurses, laboratory technicians, radiology technicians, etc. (MSPP, 2006, p. 119-122).

243 MSPP *supra* note 240, p. 12.

244 *Ibid.*

245 Indeed, generally, the official health care system only allows about 47% of the population of the country to obtain access to health care, while in 70% of cases, traditional healers still provide front line services when a person is ill. According to the MSPP, the August 12, 2010 earthquake had catastrophic effects on the administrative and provision of services structures for the health care system in Haiti, which suggests that the situation may have further deteriorated since then (MSPP, supra note 196, p. 15).

246 Lamour et al., *supra* note 108.

aimed to provide rapid and effective treatment for patients suspected of having cholera,[247] and played a particularly important role in patient care.[248] Some CTCs even developed systems to identify community-acquired infections and deaths by creating field teams.[249] In more remote areas, cholera treatment units (CTUs) were set up to allow patients with mild to moderate symptoms to be treated or, in more serious cases, to receive emergency hydration before being transferred to a CTC. Oral rehydration points (ORPs), namely, satellite stations to treat mild illness, which were generally operated by community health workers, were also set up in certain communities.[250]

A) THE POTENTIAL ROLE OF THE CHOLERA PATIENT CARE SYSTEM IN CREATING A CONSOLIDATED DATABASE FOR VICTIM IDENTIFICATION

The reason why patient care facilities are so promising as a way to identify patients who visited a health centre is that these facilities are under MSPP responsibility and must comply with Haitian law and national requirements for recordkeeping and notification of cases to the designated authorities. Their records should contain basic information on the identity of the cholera patients they treated[251] and deaths should have been recorded.[252]

Preliminary information gathered in the field appears to confirm that records were kept in accordance with MSPP protocols,[253] including the name, age, sex, time of arrival, time of specimen collection (if any), origin of the patient and his or her telephone number. Deaths were recorded and reported to the State in accordance with the requirements of Haitian law.[254] There may be databases containing relevant information stored at different levels, and which would allow maximum information to be gathered about the victims (who visited formal institutions) in order to create a consolidated database.[255]

In order to create such a database, the best place to start would be to consult the information held by the departmental health directorates. The records available on cholera patients and cholera deaths that occurred in institutions are managed on site in paper registers which may contain victims' names and other information.[256] Where that is not the case, this data (though incomplete and imperfect) could at least be found in the records of the facilities that provided direct patient care at the local level, either CTCs or pre-existing health care facilities.[257] The MSPP could confirm the archiving procedures and the exact storage locations and act as a facilitator. A partnership could thus be established between these different structures in order to consolidate the existing data.

247 MSPP, *supra* note 196, p. 22.

248 It appears that when the specific facilities for cholera care were created, the pre-existing facilities were supposed as far as possible to refer suspected cases to the CTCs and CTUs instead of treating them at their establishment, in order to limit the risks of contagion. In this sense, these specialized facilities probably accounted for a significant percentage of the recorded cholera cases.

249 For example, Zanmi Lasante and REAL HOPE. The latter, based on a photo of the patient or the deceased individual, communicated with local authorities and community leaders in the area to identify them. Moreover, between 2011 and 2016, 6 volunteer brigadier agents were responsible for administering first aid to patients to allow them to reach the nearest CTC and to collect information about deaths in the community in the area of Cazale in a registry provided for that purpose. (Lamour et al., 2018).

250 MSPP, *supra* note 196, p. 22.

251 "Any physician, … nurse … or other person aware of a disease mentioned in the following list, shall immediately notify the Public Health Officer thereof, namely: Asian cholera, …." "Any physician who treats any of the above-mentioned diseases … shall immediately provide a report to the Public Health Officer" (*Code d'Hygiène Publique (Public Health Code), p. 60-61, para. 7).*

252 "Any funeral director or other person having responsibility for or possession of or preparing for burial, the corpse of any person who died of any of the listed diseases … shall immediately report the death to the Public Health Officer stating the name of the deceased, the place of death, the date and time of burial …" (*Code d'Hygiène Publique* (*Public Health Code*), p. 61, para. 8).

253 Lamour et al., *supra* note 108.

254 *Ibid.*

255 *Ibid.*

256 Although this study only observed the situation in four departments and therefore cannot confirm that this is the case in the health directorates of all ten departments in Haiti, the information gathered suggests that it is avenue that is well worth exploring. In fact, the people interviewed in Grande-Anse and Nord confirmed that the records of their respective health directorates contained the names of persons who were admitted to and treated by these institutions.

257 Lamour et al., *supra* note 108.

THE LIMITATIONS ON CREATING A CONSOLIDATED DATABASE USING THE CHOLERA PATIENT CARE SYSTEM

Although these findings look promising, there remain a number of challenges regarding the extent, quality and reliability of the information available.

First, the primary role of the structures that have relevant data and information was to control the epidemic and eradicate the disease.[258] Thus, the data was not compiled with a view to identifying victims. In addition, when the cholera epidemic broke out in October 2010, the formal health care system was quite simply unprepared to face such a crisis and the medical profession was caught off guard by the emergence of a new disease. Not until 2011 was there a strategy to control the epidemic developed.[259] The formal health care structures (both the pre-existing facilities and those created specifically to manage the cholera epidemic) were overwhelmed, especially during the epidemiological peak of the disease (2010-2013). Better control was achieved as of 2014. There is therefore every reason to believe that the available documentation will reflect the management capabilities of these institutions at any given period, with 2010 to 2013 being especially likely to be characterized by substantial information gaps.[260]

In addition, considerable differences in the records (extent and quality of the data) and storage (preservation of information) may be expected from one facility and one geographic zone to another. These disparities may be explained by differences in financial resources, as some facilities with more rudimentary resources and operating methods (such as the smallest SSPEs and the ORPs) are more vulnerable. In Haiti, 30.62% of the institutions that make up the health care system are all public. The private sector remains very active in the treatment of disease. Differences in funding methods have therefore led to certain disparities in the administration of these institutions. The same can be said of the cholera treatment structures (CTCs, CTUs or ORPs) since they are run by independent organizations. They operate with relative autonomy and are governed by the specific rules and internal policies of the organizations that oversee their operation.[261] The information gathered in the field appears to confirm that most of the pre-existing facilities and CTCs did actually comply with national requirements; however, it is difficult to evaluate the uniformity of the information that is available from one region to the next given the geographic limitations of this study.[262] It is quite likely that certain regions have less coverage than others, notably due to storage problems.[263]

Finally, as regards data reliability, it should be noted that identity papers were not routinely required for patient admissions.[264] Given the stigmatization associated with the disease, it is possible that some patients gave false identities when they visited these centres.[265] Thus, some records may contain false names associated with real victims. In addition, some victims who gave their real names may subsequently have difficulty proving their identity for lack of formal documents, either because of deficiencies in the Haitian registers of civil status or because they lost their documents in natural disasters.[266] Information on diseases and deaths exists, but it needs to be corroborated by other sources to compensate for these gaps.

258 *Ibid.*

259 See MSPP, *supra* note 226.

260 Interview of Thierry François, *supra* note 222.

261 This information is based on interviews conducted with the administrators of organizations that ran CTCs in the departments of Ouest and Centre, including GHESKIO, Zanmi Lasante, Médecins sans Frontières Hollande and REAL HOPE.

262 Interview of Thierry François, *supra* note 222.

263 For example, in Grande-Anse, in October 2016 Hurricane Matthew caused major damage to infrastructures in most towns of the department. According to data gathered on the ground, a number of health care facilities, such as the Community Referral Hospital in Anse-d'Hainault appear to have sustained major damage which destroyed all or part of the official records that had been kept (Lamour et al., 2018).

264 Lamour et al., *supra* note 108.

265 *Ibid.*

266 *Ibid.*

B) THE POTENTIAL ROLE OF THE CHOLERA PATIENT CARE SYSTEM WORKERS IN ANALYZING MORE COMPLEX CASES

Apart from the creation of a consolidated database, cholera patient care workers might be able to identify victims in specific cases and verify information in more complex cases. All facilities i.e., local (reporting to the health coordination unit of each neighbourhood), departmental (reporting to the departmental health directorates) and national (reporting directly to the MSPP), treating patients in both institutional and non-institutional environments would be likely to hold relevant information.[267] These actors could therefore be mobilized (as information sources or witnesses) to contribute additional information or clarifications in order to verify pre-existing information or add to its scope and reliability. As a reminder, according to the field information gathered, such actors would include:

1. The members of the WHO, PAHO, UNICEF and EMIRA field teams who worked with the epidemiological surveillance system;
2. Personnel of the pre-existing patient care facilities in the Haitian health care system at the local, departmental and national levels, such as medical and paramedical personnel in the local health centres (including CSLs and CALs) reporting to the CHUs; HCRs; departmental hospitals administrated by the departmental health directorates; and national hospitals or specialized centres administrated by the MSPP;
3. Personnel of the cholera patient care facilities such as the CTCs, CTUs, and ORPs, including field personnel and community policing agents from some of the institutions that were running CTCs.[268]

Nonetheless, the mobilization of these actors in this context would be exceptional and should be limited to complex cases that cannot be decided without consulting these resources. For example, this might be the case with a victim who claims to have been admitted to a health centre, but is not listed in the departmental or local registries. These actors could thus confirm that the victim in question was indeed seen at their health centre in the event that official records have been lost (e.g., in a natural disaster) or if there was a mistake in the registration (name omitted from the registry or not matching).

2.2 Identification and verification of victims through a complementary system

It is apparent that the formal information system holds data that is essential to designing a victim identification and verification mechanism. However, the information provided by this system is incomplete and imperfect. Moreover, it is one of the main obstacles to setting up a material assistance and support package centred on the individual, as described by both the UN[269] and the victims themselves.[270]

No single facility in the formal system (be it the surveillance system or the patient care system) would by itself be able to identify and routinely and exhaustively verify the identity of all the victims, even just the institutional ones. The system was unable to keep track of all the victims of the epidemic because there was an acute lack of resources to deal with the crisis and a specific plan of action for patient care had yet to be developed. As a result, there are considerable gaps in the information, especially as regards non-institutional victims, i.e., people who were infected or who died in their communities and never visited a formal health care facility, and these represent a large percentage of the total number of victims.[271]

267 *Ibid.*

268 *Ibid.*

269 UN Secretary-General, *supra* note 21, p. 16.

270 INURED, *supra* note 79.

271 Lamour et al., *supra* note 108.

It would therefore be unrealistic to try to routinely and exhaustively identify everyone who fell ill or died across the country through the formal system alone. However, a community-based identification and verification system could complement and confirm the information from the formal system.

A number of community actors who contributed to cholera patient care have relevant victim identification information. The preliminary information gathered in the field and many of the interviews that were conducted show that these community actors would be able to help verify the pre-existing information in the formal health care system and help with the actual victim identification. They could create community lists themselves or mobilize their resources or networks as part of a larger process (See 4.2 Technical Aspects of the Process for more details on the specific role of community actors in the process).[272] They include:

1. Community actors in the SSPEs, such as health officers, birth attendants, traditional healers;
2. Spiritual authorities such as pastors and priests, *houngans and mambos;*
3. *Representatives of associations, such as members of victims', human rights, women's, vodou, and peasant farmers' associations and organizations, as well as lawyers representing victims;*
4. *Local officials and other dignitaries, such as mayors and members of the Communal Administrative Councils (CASEC) and Communal Section Assemblies (ASEC).*[273]

Due to the various activities led by these key actors in the fight against cholera, and their commitment to their communities, it is likely that they possess considerable knowledge that would enable them to identify those affected by cholera in their communal sections, particularly in rural and periurban areas.[274] They can call on community organizations and mobilize their existing networks to develop a process for identifying victims or verifying their information.[275] In fact, these leaders meet regularly, not only with members of their own communities but also with other categories of actors.[276]

The result is a complex community organization characterized by multilateral information exchange networks, which includes the data that is essential to victim identification and verification, particularly victims who were never in an institutional environment. These information networks are further strengthened by the porousness of the various categories of actors, some of whom have held multiple relevant roles or positions, either simultaneously or consecutively. For example, the *houngans and mambos interviewed were often traditional healers and the local officials and dignitaries in the area were often also community actors in the SSPEs.*[277] There was also often an overlap between these categories and the many different types of association.[278]

2.2.1 Information held by key actors and their potential role in the complementary verification system.

The community actors in the SSPEs, the spiritual authorities, the association actors and the formal and informal local authorities played a role at various levels in managing cholera in Haiti. Most of them helped to set up disease prevention and immediate assistance programs for patients.

272 *Ibid.*

273 Lamour et al., *supra* note 108.

274 *Ibid.*

275 *Ibid.*

276 *Ibid.*

277 For example, at Saint-Michel-de-l'Attalaye, the mayoress was also the former general charge nurse at the health centre and several CASECs and ASECs were also or had been health workers.

278 *Ibid.*

Although some of them invited nurses to give information sessions about cholera in their community,[279] others chose to form prevention and rapid assistance teams.[280] Still others participated directly in transporting patients to the CTCS and health centres or donated motorcycles and other means of transportation to facilitate these trips. In some areas, they advocated against certain regional cultural traditions that presented a risk of contagion.[281] Some of these actors even took in sick people who were abandoned by their families or communities, coming up with makeshift solutions and administering an oral serum made of rice water in order to hydrate the sick.[282] These actors could be mobilized since they have information they obtained while working closely with the victims.

A) THE PROMINENT ROLE OF THE SPIRITUAL AUTHORITIES

However, on a larger scale, the information gathered in the field in the areas studied indicates that it is the spiritual authorities who have the greatest capacity to identify victims and verify their information, including Christian authorities (pastors and priests) and vodou authorities (houngans or mambos). In several of the areas studied (particularly Dame-Marie and Quartier-Morin), churches developed organized systems of community information, bringing together spiritual leaders, official authorities, other types of community leaders and youth groups in order to monitor the evolution of the epidemic in their area. Members of the churches shared the information they had on the disease (including identifying members of their congregations who were sick) and its evolution in the surrounding areas by holding regular meetings.[283] In Quartier-Morin, this information system was set up in the churches by youth who were trained and sent into the field to work actively on prevention and provision of immediate assistance to the sick, redirecting them to the nearest CTCs. In Dame-Marie, a very effective decentralized and organized information system was set up. According to this system, the congregation's members were assigned to five cells associated with different geographic areas. The members of each cell met in their respective neighbourhood weekly to discuss the names and the reasons for the absence of members of the congregation. This data was gathered during their investigations in the field.[284]

The information systems set up by the vodou authorities in the areas that were studied were similar. Certain vodou leaders, particularly in Saint-Michel-de-l'Attalaye and Dame-Marie, relied on the Badekan and Hadienikon[285] to obtain information about the spread of cholera and the victims in their area. In Saint-Michel, the houngan interviewed set up a decentralized system covering eight communal sections in the commune, each of them having a designated "informant" who met with the houngan at least once a month. In addition, 12 "informants" were responsible for going house to house to obtain information about the names of those who were sick and who had died and about existing conflicts in the area, which they conveyed to the houngan daily.[286]

279 For example, a church at Dame-Marie.

280 For example, a church at Quartier-Morin.

281 For example, a *houngan* at Dame-Marie, who led awareness campaigns about the risk of washing the clothes of the deceased in the rivers, encouraging people to bury them instead. (Lamour et al., 2018).

282 For example, a *mambo* at Saint-Michel.

283 Lamour et al., *supra* note 108.

284 *Ibid.*

285 The Badekan (or hadienikon), depending on the area, are people who act as an intermediary between the houngan or the mambo and the community. The Badekan allows these spiritual authorities to obtain consistent information on topics of their choice in their respective areas.

286 Lamour et al., *supra* note 108.

B) REGIONAL DIFFERENCES IN THE INFORMAL INFORMATION SYSTEM

Even within the informal information systems, there are regional differences. While christian leaders played an important role and enjoyed greater trust among the population in certain regions, vodou leaders were more trusted in others.[287] Moreover, among vodou practitioners, it should be noted that most of the mambos interviewed had not developed information systems like those of the houngans, but were more involved in caring for the sick directly.[288] In addition, the public's degree of trust in these leaders and the strength of the social ties in each community are variable. Strong social ties and a high level of trust in these leaders generally go hand-in-hand with more developed and more reliable information systems. Although the phenomenon is somewhat marginal, it is worth noting that, in some locations, spiritual leaders were identified as untrustworthy by the population, or the community was so divided that even if such systems had been set up, they would never have worked.[289]

The preliminary information gathered in the areas studied also revealed marked dissimilarities between different regions and in the role of each community leader.[290] It would be important to consider other community actors such as associations, local authorities and community actors from the health care system. Not only could they be helpful in areas where the spiritual authorities are not as influential or lack legitimacy, but they could also be mobilized to cross-check the data. Given the geographical limitations of this study, the prominent role of the spiritual authorities in the areas studied may not reflect the situation nationally. Consequently, other community actors should be solicited in some areas and on a smaller scale.

In short, it is clear that the community actors from the SSPEs, spiritual authorities, associations and formal and informal local authorities all contributed at different levels to the management of cholera in Haiti. They have claimed that they can identify victims due to their proximity work in their communities. Some actors, particularly spiritual authorities, described relatively sophisticated local information systems that could be mobilized as part of a process to identify victims in the community and verify their information. In the absence of formal written records of victims in the community, the community information networks of these actors could play a critical role in gathering, compiling and verifying data about the sick and deceased in hamlets, communal sections and communes.

287 *Ibid.*

288 In this regard, there appears to be a gender-based division of labour between mambos and houngans, corresponding to the traditional social role of women in caring for the sick in Haitian society.

289 Lamour et al., *supra* note 108.

290 *Ibid.*

PART 4
PROPOSED MODEL TO DECIDE CLAIMS

Having raised the issues of the definition of a cholera victim and the state of the current documentation within the formal and informal information systems, it is now possible to propose the broad outlines of a model to decide on potential claims.

1. TECHNICAL ASPECTS OF THE REGISTRATION OF VICTIMS AS BENEFICIARIES OF THE PROCESS

1.1 Determining the beneficiaries of the process

Determining the beneficiaries of large-scale reparations programs generally raises complex questions regarding the evaluation of losses and personal suffering and their impact on the victims. Indeed, "Accepting that it is not convenient, nor possible, to make [these programs] proportional to an individualized assessment of the harm suffered, requires replacing the test of individual proportionality with another measure that can better guarantee fairness."[291] In other contexts, notably Peru, Chile, Colombia and Sierra Leone, this dilemma was resolved by providing "similar forms of reparations to all victims of the same type of violations, making as few distinctions between them as possible."[292]

As regards the classification of victims, when the available resources are scarce "choices have to be made and, arguably, it makes sense to concentrate on the most serious crimes."[293] The lessons learned from similar processes in other contexts are unanimous: it is essential to make sure that there is proper consultation and involvement of victims and local partners in the "definition, implementation and evaluation" of the process in order to ensure that the best adapted, most legitimate and effective process is achieved.[294] To this end, the classes of proposed beneficiaries should be determined by taking into consideration the priorities identified by the victims vis-à-vis the persons they believe were most affected by the epidemic.

We recall that, in the consultations held by INURED, the family members of the deceased were designated the "hardest-hit" victims of cholera, the financial impact associated with the death being a particular concern for this class of victims and justifying their ranking (See PART 2: Victims' perspectives benefits and risks of the individual and collective approaches). Children and young adults who had lost a parent and/or a breadwinner were considered to have suffered the most, followed by adults (particularly the deceased's spouse) who had lost

291 Correa C., *supra* note 70, p. 12.

292 *Ibid.*

293 UN Office of the High Commissioner for Human Rights (OHCHR), *Rule of Law Tools for Post-Conflict States: Reparations Programmes (2008) HR/PUB/08/1, p. 21, available at:* <https://www.refworld.org/docid/47ea6ebf2.html>

294 Correa C., *supra* note 70, p. 25-26.

a breadwinner.[295] Several of the participants in these consultations expressed the opinion that cholera survivors were the second hardest-hit victims of the disease, as cholera patients suffered long-term effects on their physical and mental health, which was thus of particular concern. However, the participants acknowledged that the needs of survivors and of close relatives of the deceased were different and that the assistance should take such differences into consideration.[296]

The point of view expressed by the victims as to the classes of victims to be given priority as beneficiaries reflects the vision expressed by the Office of the United Nations High Commission for Human Rights. According to that body, such programs are generally intended to "prioritize violations of the severest nature," frequently granting additional priority to "victims who continue to be vulnerable and suffer serious consequences," generally "violations of the right to life … and violations of the right to physical integrity."[297] Sometimes, economic harm can also be considered as a class "if [the] loss can be considered as having as severe a consequence on the [victim] as the serious violations that have been prioritized."[298]

The relevance of responding to certain needs through complementary community assistance having already been discussed (See PART 2: Victims' perspectives benefits and risks of the individual and collective approaches),[299] there are two options that reflect the victims' perspective and that may be considered for the individual component. The first option (which is more inclusive and fairer than the second, but also more costly and more complex) would consist in setting up a mechanism for deciding the claims submitted by the families of individuals who died from cholera as well as those submitted by survivors (See 1. The definition of a cholera victim and its relevance in determining who are beneficiaries). The second option would be to establish a mechanism focused on the close relatives of deceased persons, while ensuring that the specific harm suffered by survivors is addressed through a community approach.

1.2 Persons eligible to submit a claim and be considered as beneficiaries

Regardless which option is chosen, the process must above all clearly define who is eligible to submit a claim under the process and who can be considered a beneficiary. The process must be fair and include as many real victims as possible (including PSVs), while being sufficiently rigorous to limit over-inclusion and the risks of family conflicts. There is considerable variability among the relevant comparative examples for the design of such a process, but certain criteria can be extrapolated.

In the Philippines,[300] the criteria were relatively rigid, being limited to victims of human rights violations (or to claimants who were presumed to be the victims of human rights violations), their legal heirs under Filipino law (in case of death) or the authorized representatives of

295 INURED, *supra* note 79.

296 *Ibid.*

297 Correa C. and Gbery D, *supra* note 128, p. 2.

298 *Ibid.* p. 3.

299 The effectiveness of such mechanisms and their usefulness in addressing the specific needs of the "hardest hit" victims would then depend in large part on their ability to specifically prioritize these groups of persons and take the specificities of their situation into consideration, as described above. Thus, according to Cristián Correa, one possibility is to adopt an incremental strategy, which could include "support efforts for relief to victims, or assistance projects that may provide opportunities for social and economic improvements to people in those countries, making sure that … victims [specifically] are included in the targeted population." (Correa, p. 23). Thus, based on the victims' priorities expressed in INURED's consultations, such programs could include: health care centred on the management of the medium and long-term physical consequences of cholera; mental health monitoring focusing on the psychological distress of direct victims and their families; scholarships for children who have lost a breadwinner during outbreaks or epidemics; job creation for direct victims and their families. In this respect it is essential that these programs take into consideration related costs that may prevent victims from fully benefiting from such programs (INURED, 2018).

300 Reparations program introduced in the Philippines following extra-judicial killings, torture, forced disappearances and other serious human rights violations during the regime of former President Ferdinand E. Marcos between 1972 and 1986 (See, for example, Sarmiento, L.C. et al., *Implementing Rules and Regulations of Republic Act No 10368 "An Act Providing for Reparation and Recognition of Victims of Human Rights Violations During the Marcos Regime, Documentation of Said Violations and Appropriating Funds Therefor and for Other Purposes," Quezon City, Philippines, 2014.)*

such victims.[301] In Peru,[302] those eligible to submit a claim included the victim or a member of his or her immediate family[303] (including a spouse or partner, children and parents),[304] who could additionally submit the claim through a legal representative. Exceptionally, claims could be filed by a third party "when it is clear that the victim or his family members would have difficulty submitting the claim."[305] As for victims who were minors, legally incapable or with no living family members, the communal, political or ecclesiastical authorities could make the claim on their behalf, with the presumption that there was no family if it proved impossible to find relevant information despite an investigation.[306]

In Haiti, with regard to survivors, if the preferred approach were to recognize them as beneficiaries, they would be able to submit a claim in their own name (or failing that, their legal or other representative could do so). With regard to the family members of a deceased person, determination of a person's eligibility to submit a claim and be considered a beneficiary is more complex. Although Haitian inheritance law may serve as a guide in this exercise, it should be noted that the use of these legal parameters frequently results in the exclusion of all beneficiaries who are the offspring of informal unions and in the over-inclusion of legal heirs (particularly more "distant" members of the family) who are not necessarily the victims most affected by the death.[307] Thus, given the complex family structures in Haiti – associated for example with polyamorous relationships, married couples who are separated but not divorced and who have remade their life with another person, and multiple cases of formal and informal adoption,[308] excessively rigid criteria would limit victims' access to the program. The criteria applied should be flexible in order to include the most vulnerable individuals, particularly women in informal unions (concubinage, *plaç*age, mistresses) and the offspring of such relationships. Furthermore, this would be in keeping with the principle of equality of filiation contemplated by Haitian law.[309]

Any member of the immediate family – whether a) partners (official or not); b) children (biological or not); or c) a close relatives of the deceased person – should be considered a potential beneficiary and be eligible to submit a claim under the program, as long as they are able (based on the balance of probabilities standard) to prove their filiation with the victim (For the determination of the amount and its distribution among beneficiaries in the same family, see 4.3 Determination of the Amounts and Distribution of the Assistance.)

To take these complex circumstances into consideration without bogging down the process, Chile had limited the inclusion of partners in informal unions to the mothers of children conceived in such unions.[310] While this excluded permanent partners without children from the process, it allowed PSVs to be included, and gave priority to permanent unions that were "active" at the time the victim died, rather than being simply limited to those that were easiest to document. In Haiti's case, insofar as the victims have identified children as a particularly vulnerable group, this proposal could be a way of mitigating the exclusion of PSVs and the most frequent complex family structures (and thus limiting the risks of family conflicts) while ensuring a certain consistency and taking into consideration both the victims' priorities and considerations related to technical, financial and administrative feasibility.

301 *Ibid.,* Art. 3.3.

302 Reparations program introduced in Peru following torture, illegal detention, sexual violence, recruitment of child soldiers, mass relocations and other serious human rights violations committed during the domestic armed conflict between 1980 and 2000 (See, for example, ICTJ, *Reparations in Peru: From Recommendations to Implementation* (June 2013) available at: ictj.org <https://www.ictj.org/sites/default/files/ICTJ_Report_Peru_Reparations_2013.pdf>).

303 Consejo de Reparaciones, *Reglamento de inscripción en el Registro* Único *de Víctimas de la Violencia a cargo del Consejo de Reparaciones* (2008), available at: drive.google.com <https://drive.google.com/open?id=0Bwx9OXgv2Dn6ZTZrWGE4c0Ytanc5aXBrNjE1MW50elprQkk4>, art. 50.1.

304 *Ibid.* art. 4.

305 *Ibid.,* art. 50.2.

306 *Ibid.*

307 Interview of Cristián Correa by LWBC (December 19, 2018) Montréal.

308 INURED, *supra* note 79.

309 In fact, "The principle is established of equality of legitimate, natural, adoptive, or other filiations, which necessarily implies the equality of all children, whether born in or out of wedlock." and in this regard "all children … enjoy the same prerogatives in all matters", including in matters of inheritance (*Law on Paternity, Maternity and Filiation* (June 4, 2014) Le Moniteur 169(105), art. 1 and 11.

310 See: REDRESS, *Reparations for Torture: Chile (1992) available at: refworld.org <https://www.refworld.org/pdfid/4bf3a0522.pdf >.*

Other more distant members of the family should be able to submit a claim and be considered as beneficiaries. However, such requests should not be considered unless no other application by partners, children or parents of the victim is received within the time allotted for submitting a claim. Accordingly, a strict and transparent deadline for filing claims would bring a certain degree of clarity and finality to the beneficiary registration process.

In the absence of living family members or in the case of minor or incapable victims, the local authorities or other community leaders might be eligible to submit a claim on behalf of a beneficiary, as was the case in Peru. These criteria would make the process accessible to the greatest possible number of victims while limiting the risks of fraudulent claims of filiation.

1.3 The standard of proof for establishing the status of victim

The proposed model must guarantee the accessibility of the process to the victims, allow fair and consistent decisions on all claims while being realistic given the above-mentioned constraints. The balance of probabilities (or preponderance of the evidence) standard is a fair basis that is routinely used in civil law and in comparable programs.[311]

In order to establish victim status on a balance of probabilities in the Haitian context, use of the medical definitions of "suspected case of cholera" and "death attributed to cholera", as established by the MSPP based on the epidemiological evolution of the disease, would provide precise and relatively reliable criteria for deciding claims. Thus, taking into account the specific situations described above (See 1.2 Determining the status of cholera victim and its applicability: medical and practical considerations), the status of victim for survivors aged two and over could be based on the MSPP's official medical definitions of "suspected case" in each phase of the epidemic (2010-2013; 2014-2016; 2017 to present). As for deaths, provided that the standard of "suspected case" is met, there should be a presumption of death attributable to cholera for all victims aged five or over, if the death occurred within a few days of symptoms being reported. When supported by proof, a simple match with these definitions would thus be sufficient to meet the standard of proof requirement based on a balance of probabilities in the case of cholera victims.

In cases where the proof supplied raises substantial doubts (for example, due to limited evidence) so that the standard of proof is not immediately satisfied, it should be possible to remedy the deficiency by considering: the severity of the victim's symptoms (which can be estimated in light of the medical or traditional healing treatments received or the duration of the symptoms, for example); epidemiological data relating to national outbreaks (during the epidemiological peak from 2010 to 2013) or regional and local outbreaks (from 2014 onwards); any other relevant contextual information. Such contextual data would thus provide additional details in order to rule on the probability of whether it was a suspected case of cholera after evaluation of the evidence presented.

The contextual information would be particularly relevant in deciding on more complex cases, particularly those involving children under the age of 5. For these cases, data concerning outbreaks, contact with another suspected case of cholera (e.g., a family member) and the conduct of a rotavirus vaccination campaign in their locality would be relevant contextual elements that would help decide on these specific cases (See 1.2 Determining the status of cholera victim and its applicability: medical and practical considerations).

It should be noted, however, that, according to the UN, "The more demanding the evidentiary requirements, the more false claims will be excluded; but so will perfectly legitimate claims, preventing the programme from achieving completeness."[312] Thus, "in a [large-scale] context, the need to guarantee accessibility to all victims …, especially those with more difficulties

311 See, for example, Correa, C., *supra* note 70.

312 UN Office of the High Commissioner for Human Rights, *supra* note 293, p. 18.

to present evidence or to [be heard], may require usual measures of strict proportionality to be complemented or moderated."[313] Consequently, this type of administrative process does not "need to apply judicial standards of proof. Instead, it may be more appropriate to uphold administrative standards that are more in line with the resources of [the institutions administering it] (given the often large number of victims …) and the capacity of victims to meet [the standard]." [314] For example, in Peru and the Philippines, it was the existence of "substantial evidence" that allowed claims to be decided, as the data analysis had to "consider the existence or non-existence of reasonable indications for presuming" victim status.[315]

So, in these cases, a more flexible administrative standard than the balance of probabilities standard was applied since the use of a judicial standard of proof created significant risks in terms of lack of financial and administrative resources and accessibility for the victims, particularly the most vulnerable. Although it does not appear to be necessary to completely alter the proposed standard of proof in this case, the risk of insufficient resources and under-inclusion of victims, particularly PSVs, justifies supplementing the requirements of this standard of proof described above.

As a reminder, between 2010 and 2013, there was a high probability that a patient presenting with severe acute diarrhoea with or without vomiting (according to the MSPP definition) was actually suffering from cholera given the epidemiological peak and the size of the outbreaks across the entire country. Moreover, the number of victims who were unable to obtain formal care during that period (and therefore have more limited physical proof) was particularly high. Although the probability gradually began to decline between 2014 and 2016, it remained significant. It was not until 2017 that the probability fell substantially as the epidemiological evolution of the disease gave rise to a redefinition of "suspected case" to include signs of dehydration and the absence of fever and bloody stools (See 1.2 Determining the status of cholera victim and its applicability: medical and practical considerations).

Nevertheless, although the official definitions of a suspected case of cholera varied in each of the epidemiological phases of the disease (2010-2013, 2014-2016, 2017 to present), determining the victim status of each claimant on the basis of the specific nature of the symptoms associated with each period would place an excessive burden of proof on the victims, especially the most vulnerable, and would needlessly overload the process, for it would require the victims to prove the absence of certain symptoms in order to establish their victim status and the process would be made more complex by the need to decide on an additional element. Moreover, such a distinction would be of limited practical use given that with the significant drop in the number of cholera cases starting in 2017, such cases represent a very small percentage of the total number of victims. So, in order to treat claims fairly, the same definition of suspected case should be used, regardless of when the victim contracted or died of cholera.

Thus, the standard of proof (on a balance of probabilities) should be considered to be met if the claimant manages to show, according to this standard of proof, that his or her case matched the original definition of a suspected case of cholera as established by the MSPP, namely, severe acute diarrhoea with or without vomiting.

These complementary elements, which allow the burden of proof to be met on the balance of probabilities would thus allow fair and efficient decisions to be made on victims' claims, while mitigating the risks of fraud, over-inclusion, under-inclusion and mismanagement of the available resources. They would allow a certain degree of inclusion, fairness and accessibility of the process to cholera victims, especially the most vulnerable, while optimizing the allotted administrative and financial resources.

313 Correa, C., *supra* note 70, p. 10.

314 ICTJ, *Forms of Justice: A Guide to Designing Reparations Application Forms and Registration Processes for Victims of Human Rights Violations* (December 2017) available at: ictj.org <https://www.ictj.org/sites/default/files/ICTJ_Guide_ReparationsForms_2017_Full.pdf>, p. 7.

315 See Consejo de Reparaciones, *supra* note 303.

1.4 Acceptable proofs

"Ensuring that documentation requirements are not burdensome is particularly important in situations where victims may number in the tens of thousands or live in remote locations or experience economic hardship."[316] Because many victims and potential beneficiaries "are marginalized by poverty, illiteracy, ethnicity, caste, or gender, they may not be able to apply for reparations on their own." Many may not "possess or easily access the documentation or information they need to support their application."[317] As for documents that are required or admissible, proof in and of itself "should not be equated with the level of proof typically needed in a court of law or even civil proceedings. Without completely dispensing with ways to prevent fraud, what matters most … is [to] require the minimum level of information needed to determine a victim's eligibility without placing an undue burden on the victim."[318]

In similar contexts, (notably the Philippines,[319] Peru[320] and Colombia) the victims had to submit: a) a proof of identity prior to the facts; and b) a proof of their victim status (including the harm suffered, with dates and times). As for deceased victims, in addition to these proofs for the victims themselves, claimants also had to provide: a) proof of their own identity and b) proof of their filiation with the victim. The determination of identity (1), victim status (2) and filiation (3) in this type of program commonly relies on the existence of so-called "substantial" (or "reasonable") proof.

The proposed mechanism cannot be based solely on formal written proof, since that would exclude the vast majority of deaths that occurred outside institutions, increase the risk of a black market for forged documents,[321] foster family and community conflicts, re-victimize many PSVs and automatically exclude certain geographic zones.[322] That being the case, by basing decisions on documents deemed admissible in similar programs (e.g., in Peru[323]), the following proofs could therefore be considered admissible, including:

1. **Proofs establishing the identity of the victim or the claimant:** any copy of a document attesting to the victim's identity, such as an identity card, a birth or baptismal certificate (ideally issued before the facts). For victims without documents, the following elements could be considered: an affidavit from a competent person; a sworn statement by the victim or the claimant that he or she has no documents or that his or her identification documents were destroyed. These proofs would make up for deficiencies in identification documents in Haiti, particularly for PSVs.
2. **Proofs establishing victim status:** Any proof of confirmation of the disease (medical certificate or copy of medical record, receipt for health care or loan or other proofs – videos, photos, SMS, voicemails, etc. relating to the provision of traditional healing treatments, etc.) or of death (death certificate, extract from the morgue registry, copy of a burial licence, receipts for burial or usurious loan or other proof relating to the holding of a wake). In the absence of such documents, the following would also be accepted: any other proof attesting to a request for such an official document or proofs relating to facts surrounding the illness or death; an affidavit from a competent person that corroborates the information; sworn statements by witnesses, including at least one member of the medical or health staff (for victims who died in institutions) or a civil, ecclesiastical or other credible community leader

316 ICTJ, *supra* note 314, p. 2.

317 *Ibid.*

318 *Ibid*, p. 7.

319 Sarmiento, L. C. et al., *supra* note 300, art. 5.10.

320 Consejo de Reparaciones, *supra* note 303, art. 10, 11, 15, 23.

321 Official documents such as medical certificates and death certificates must be treated like any other physical proof, but should not be enough to establish victim status due to the non-negligible risk of forgery. Their reliability should therefore be assessed on a case-by-case basis in light of the possibility that they may be counterfeit, knowing that certain elements (especially dates) offer clues to the reliability of such documents (Piarroux, 2018).

322 For example, although Saint-Michel-de-l'Attalaye is one of the communes that was hardest hit by the epidemic, not one medical certificate was issued.

323 Consejo de Reparaciones, *supra* note 303, preamble para 6.

(for victims who died in the community), that match the victim's or the claimant's account of the facts. Given the considerable limitations on the value of medical certificates, these should be given the same status as all the other admissible proofs mentioned.[324]

3. **Proofs to establish the filiation of the claimant (for close family members of deceased persons):** a copy of documents attesting to the relationship with the victim (filiation, union, cohabitation, child or any other relevant relationship); proof of payment of tuition fees; affidavit from the claimant; testimony of a credible member of the community.

It is important to consider a variety of proofs in order to make up for gaps in the Haitian registers of civil status.

It should be noted that in the vast majority of cases, an appropriate final decision on claims will rely on a combination of proofs, including physical proofs and testimony,[325] and contextual elements.

2. TECHNICAL ASPECTS OF THE PROCESS

The potential beneficiaries, the persons eligible to submit a claim, the standard of proof and the admissible proofs having been determined, it is now possible to outline how a model to decide the beneficiaries' claims would work.

In accordance with international standards[326] and the practice in similar circumstances, reparations and assistance programs are generally based on transparency, on measures to mitigate fraud and conflicts, and are characterized by quick and efficient procedure.[327] Even before the process is launched, it is essential to set up an effective, precise, proactive and accessible plan of communication and awareness-raising and to develop an information network to disseminate the necessary information throughout the process.

It is essential to explain to the public the steps in the process, the eligibility criteria, the time limits for submitting claims and the penalties for false statements. It is also important to clearly explain the specific objectives of the individual component of the package and how it fits into a broader response to the victims, while insisting on the symbolic nature of the process rather than the outcome itself.[328] A good understanding of the process and its limitations will ensure transparency while avoiding unreasonable victim expectations and the risk of conflicts due to fraud and false statements.[329] Existing traditional means of communication may be mobilized for this purpose.

324 Indeed in most cases, cholera victims have no "official" document attesting to their condition, Moreover, these documents are not specific: whereas medical certificates rarely state the exact reason for admission to a health centre (most documents indicated "suspected case" or that the person was simply admitted for "acute diarrhoea"), Haitian death certificates are not designed to specify the cause of death. It is also important to remember that according to the victims, certain centres refused to issue certificates even when requested to do so, while other centres demanded "administrative" payments to issue them, which could be a significant obstacle to victims seeking to obtain such documents (INURED, 2018).

325 Given the lack of information, testimonial proof will probably play a dominant part in this process. It should be noted that Haitian law is strongly focused on testimonial proof, partly as a result of the informal social structures (particularly in rural areas) the gaps in information and the lack of resources of the judicial system (Lamour, 2018).

326 *Basic Principles and Guidelines on the Right to a Remedy and Reparation, supra* note 56, comment 31.

327 Sarmiento, L.C. et al., *supra* note 300, art. 1.2.

328 Interview of Cristián Correa, *supra* note 307.

329 *Ibid.*

How the claims process works varies depending on the classes of victims and the harms suffered as well as the context. In Peru, the Philippines and Colombia, reparations programs were based on a process of voluntary registration by victims (rather than a proactive search for victims, which would have been too costly). The data was then cross-checked against a consolidated formal database, then verified with local sources, if necessary, with investigators sometimes being sent into the field to confirm the information.[330] In fact, "during the assessment and qualification, if applicable, the coherence of each test will be analyzed, the information sources will be cross-checked by looking for consistency with other existing tests and with the [consolidated] databases."[331]

Thus, the model for deciding claims is generally based on three main structures:

1. A local structure (responsible for registering claims, local verification of basic information and a preliminary opinion on the case);
2. A regional structure (responsible for issuing a first technical opinion on the case and requesting additional information from the local structure if necessary);
3. A centralized unit (namely, the decision-making body responsible for deciding on the claim by handing down a final decision or requesting experts in the field in very complex cases);[332]

In its simplest form, the process thus usually unfolds as follows:

1. A claimant files a claim at the local level;
2. The information is cross-checked against data in the formal system at the regional level (generally using a previously consolidated database);
3. The information is verified with local sources (for victims who do not appear in the formal database and whose basic documents submitted are insufficient to decide on their claim);
4. Investigators are sent into the field (in more complex cases, generally a very small minority of the total number of cases received);
5. The decision-making body makes its final decision.[333]

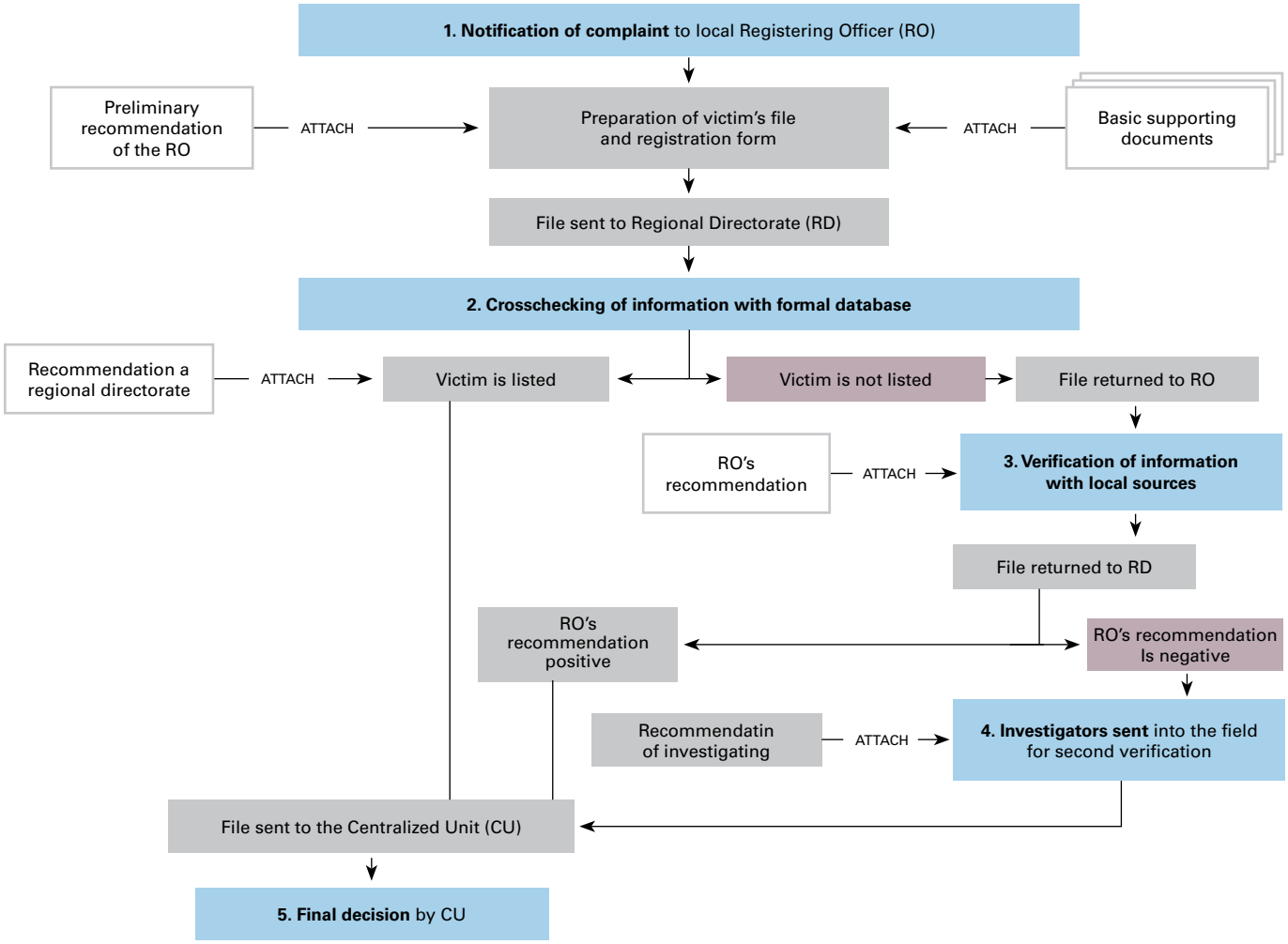
330 Interview of Cristián Correa, *supra* note 307.

331 See, for example, Consejo de Reparaciones, *supra* note 303.

332 Interview of Cristián Correa, *supra* note 307.

333 *Ibid.*

The general structure of the model proposed in this case may thus be illustrated as follows:



2.1 Victim registration

As its title indicates, this stage is the one during which the person eligible to file a claim submits it to a registering officer (RO) in his or her area so that it can be registered. The claimant must complete the registration form and attach any supporting documents (proof) in their possession.

Since these assistance programs have to "cover as many qualified victims as possible and to acknowledge them collectively and individually," the processes used should have a reparatory function and "transcend their administrative, legal, and physical function, becoming in themselves a means of acknowledging and reaffirming the dignity of victims who apply."[334] Indeed, this is one of the main criticisms that victims have expressed about the registration process in other contexts: filling out the form and waiting for it to be reviewed and registered, "can become overly bureaucratic, inaccessible, and even oppressive."[335] In order to guarantee accessibility, the procedure must also: be conducted entirely in the local language; be as simple as possible for the victims; be completely free of charge (including related costs); and be decentralized (thus limiting travel costs). However, it must be limited in time (with predetermined time limits that are communicated in advance to the victims) in order to reduce unnecessary administrative expenses, victim suffering and risks of fraud,[336] while allowing a reasonable time for registration.[337]

As for the registration forms, they must of course be adapted to the circumstances, although there exist certain general standards in this regard.[338] It is generally agreed that they should include: a) basic personal information about the victim (and the claimant, if not the same person);[339] b) a description of the harm suffered; c) data to verify the person's identity; d) data to verify filiation in claims based on the death of a close family member; e) a list of acceptable and necessary types of supporting documentation; f) a declaration of truthfulness.[340] The claim should also include a list of third persons who can attest to the truth of the facts alleged, whether they are persons who provided conventional care or traditional healing, helped the victim to obtain care, helped to bury the deceased or supported the family in any way, or any other credible person with knowledge of the facts. Where deemed necessary, the claim may be accompanied with a questionnaire to assess the vulnerability or handicap, the harm suffered and the impact of the disease on the claimant's life.[341]

Claimants should receive active assistance from the RO to fill out the form properly and to attach the supporting documentation necessary for processing their file. The ROs are the front line in the process, in that they act as intermediaries between the victims and the higher instances. Apart from their administrative duties, their primary objective should be to ensure that the process is made as accessible as possible for the victims. Thus, in addition to helping to complete the forms as necessary, they should also interview each claimant in order to verify the accuracy of the information provided, while reiterating the specific objectives of the process and the consequences of making a fraudulent declaration.[342]

334 ICTJ, *supra* note 314, p. 1.

335 *Ibid.*

336 Interview of Carla Ferstman by LWBC (March 2018), Port-au-Prince.

337 The concept of reasonable time varies a great deal depending on the circumstances (including the number of victims, the available resources, the extent of information available, etc.) For example, in the Philippines, registrations were open for 6 months (art. 5.1).

338 For more information about the development of a suitable form, see ICTJ, *Forms of Justice: A Guide to Designing Reparations Application Forms and Registration Processes for Victims of Human Rights Violations* (December 2017) available at: ictj.org <https://www.ictj.org/sites/default/files/ICTJ_Guide_ReparationsForms_2017_Full.pdf>

339 This should include the name of the victim and the members of his or her household or the beneficiary: age or date of birth; occupation or source of income; gender, status (relative to the spouse, parent, child or any other member of the family); address; contact information; special vulnerability criteria.

340 ICTJ, *supra* note 314, p. 16.

341 *Ibid.*

342 Interview of Cristián Correa, *supra* note 307.

Moreover, "it is important, throughout the registration process, to provide [claimants] with updates at appropriate times[343] and help them overcome the difficulties encountered in locating information or accessing documents."[344] Indeed "an essential part of a transparent and effective process consists in clear procedures and notifying the victims of a probable decision and giving them the opportunity to complete their claim or, in the event of rejection, review procedures," as the case may be.[345] Although it is true that these measures require an additional investment in "time and resources, they mitigate the potential for errors and allow victims to remedy gaps in their claim so that they can obtain" the assistance to which they are entitled.[346]

After helping to register the victim's information and prepare the file, the RO should verify the information and issue a preliminary recommendation on the status of the file. In more complex cases, or cases where the victim does not have substantial proof to support his or her claim, the RO should notify the victim so that he or she can complete his or her file and make inquiries with local sources.[347] In order to limit the number of files that have to be returned to the local level for further investigation, the ROs should therefore attempt to confirm the general information provided by the victim and assess their general credibility. This may mean conducting preliminary inquiries at the local level, with the third parties identified on the form by the victim as being able to attest to the truth of the facts alleged, and with other credible community sources (See 2.2 Identification and verification of victims through a supplemental system.

In order to verify certain information in the file, the ROs will need to contact a third person or community actors. It is essential that ROs be able to build healthy and cordial relations within the communities where they are deployed while retaining their independence and neutrality. Maintaining good relations is a decisive factor for the effectiveness of the process.[348]

In short, the RO must ensure that the form is correctly filled out, verify the information in the file and review the proof in order to make a decision on the victim's identity, the victim's status and filiation, if necessary.[349] The RO must then give the victim a receipt for the claim and inform him or her when the preliminary verification has been completed. The RO must then decide whether it is a more complex case that requires additional inquiries or a case that appears a priori to satisfy or not to satisfy the predetermined criteria.[350] The RO's preliminary findings must be recorded in writing and included in the claimant's file.

RO staff must absolutely be Haitian. They could be recruited among young professionals with a background in social sciences and humanities[351] or recent graduates in these fields[352] working under the supervision of more experienced professionals. Before their deployment, they should be trained in the technical and administrative aspects of the process, but also

343 Providing networks through which claimants can keep abreast of the evolution of their claim and the final decision may be particularly difficult in Haiti, especially for marginalized groups who have limited access to traditional means of communication. However, the occurrence of these problems may be limited by requiring the claimant to provide several ways of communicating with him or her at the time of registration (e.g., several telephone numbers of people easier to contact with the consent of the claimant who can receive updates about their file, for example family members or community leaders). This could also be achieved through predetermined follow-up days set by the RO in each area with dates and locations being communicated to the victims in advance through a transparent and adapted communication strategy. These days would allow updates to be communicated to claimants and give them an opportunity to complete missing information in their file if necessary. Ideally, to make the process accessible, visits could be scheduled at key times when the beneficiaries could travel to more central areas, e.g., market days or Sundays after mass.

344 Correa, C. *supra* note 70, p. 44.

345 *Ibid.*, p. 42.

346 *Ibid.*, p. 42.

347 These tasks are consistent with those performed by persons in charge of registration in a reparation process implemented in Peru. They were responsible for: verifying that the information was complete, orderly and supported by corresponding supporting documentation; completing incomplete, insufficient or incoherent files; preparing a technical report for each case registered (Sarmiento, L.C. et al., *supra* note 300, art. 39).

348 Interview of Cristián Correa, *supra* note 307.

349 *Ibid.*

350 *Ibid.*

351 *Ibid.*

352 The use of students could be done through a partnership with the State University of Haiti and with other Haitian universities that are recognized for the quality of the social sciences and humanities professionals that they train. Such a partnership would give access to a sufficiently large pool of professionals to study each commune in the country while reducing the costs associated with their deployment. This would also allow young professionals to gain experience working in their field, which would be an investment in the advancement of Haitian society (Interview of Cristián Correa, 2018).

in the ethical aspects of their work and the approaches they should adopt to avoid harming the victims. Each commune should have several ROs to ensure efficiency and speed and avoid concentrating too much "power" in the hands of a single individual.[353] As a preventive measure, to limit the risks of personal and community conflicts of interest or of corruption or fraud among ROs, staff should not be assigned to their community of origin or of residence or to areas where close relatives reside. There also needs to be assurance that their living conditions in the field (including salary, but also lodging and access to basic goods and services) are reasonable.[354] Control mechanisms should be implemented to ensure the quality of the ROs' work and their integrity. These mechanisms could take the form of audits conducted by officers from a higher level, or complaints filed by claimants. This would avoid corruption or fraud among officers.

2.2 Cross-checking information against data in the formal system and preparing an initial technical opinion on the file

Once the registration procedure has been completed and a recommendation issued by the RO, the file would be referred to the Regional Directorate (RD) where the data would be cross-checked against information in the formal system (preferably already consolidated in order to accelerate the process and optimize the available resources) in order to verify the information provided by the victim (See 2.1.2. Cholera patient care system and the potential role of the cholera patient care system in creating a consolidated database for victim identification).

Additional research would only be conducted in cases where the information does not match. If the victim is not listed in the database or if significant discrepancies between the information supplied and the information in the database raise serious doubts, the RD should contact the RO and provide details of the reasons for the doubt or the missing documents in order to decide the claim efficiently. The RO shall then notify the claimant and give him or her the opportunity to submit additional proofs, and to try to verify the missing information with local sources before returning the file to the RD.[355]

This phase of cross-checking the information with local sources (See 2.2 Identification and verification of victims through a supplemental system.) is particularly important as it has the effect of reducing the risks of both under-inclusion (by allowing the most vulnerable victims – and therefore the ones whose files are least well documented – to complete missing information using less "traditional" sources) and over-inclusion (by cross-checking the information).

While working directly with community sources may raise the risks of fraud, it should be noted that these sources would have no decision-making role, meaning that they would play no part in deciding a victim's claim. Their decision-making influence would also be limited by cross-checking the information submitted against multiple (community, but also formal) sources, thereby ensuring that the process satisfies certain minimal standards of reliability and credibility and reducing the considerable pressure that could be exerted on community leaders to over-include victims in their testimony. Since all the information would be verified with multiple sources in parallel and there are many victims in each zone, the credibility of the actors is ensured.

Furthermore, the inclusion of these sources (particularly leaders who have the trust of their community) as advisers would reinforce the accessibility and legitimacy of the process (and thus its acceptance by the public), guarantee a certain degree of transparency, but also reduce the risk of conflicts that may arise during the process.[356] Some communities

353 *Ibid.*

354 Interview of Carla Ferstman, *supra* note 336.

355 Interview of Cristián Correa, *supra* note 307.

356 Interview of Cristián Correa, *supra*¸ note 307.

have informal dispute settlement mechanisms using networks of these community actors, which have in some cases been used effectively for generations.[357] These networks could be mobilized in case of conflict. In zones where community links are weaker or strained (and where the implementation of the process might be more likely to give rise to conflicts), it may be possible to reinforce existing community structures for conflict resolution or to create new ones as a preventive measure.

If the information submitted is corroborated by the information contained in the database or new information provided by the RO, it will then be possible for the RD to prepare an informed technical opinion on the case based on the previously established criteria (context, actions taken by the RO in the file, factual analysis and the RO recommendation as to the victim's/beneficiary's eligibility) before sending the file to the Centralized Unit (CU).[358]

2.3 Analysis of the technical opinion, final decision on the claim, and notification of the victim

Once the file is received by the CU, the RD's technical opinion is reviewed for approval, then a final proposal is drafted, with the final decision to be made unanimously by the members of the council of the CU.[359] In the event of substantial doubt (generally reserved for cases that were previously identified as very complex), additional consultations or investigations may exceptionally be requested by the CU. However, in a spirit of efficiency and optimization of resources, the RD's technical opinion is generally accepted as is, following summary verification for relatively simple cases. To ensure consistency in processing claims and in the decision-making process nationally (and therefore its fairness), the RDs must nevertheless be audited occasionally by the CU, for example, by analyzing a sampling of files.

Looking at other similar contexts, it should be noted that the number of members making up the decision-making body and the criteria for their appointment vary considerably from one process to another, depending on the available resources notably, but also on the specific needs and objectives of each process.[360] Regardless, the appointment of members is always reliant on a certain degree of probity, competence and integrity, which also demands substantial knowledge of and considerable commitment to the program's particular area of concern, in this case, cholera and human rights.[361]

Following the CU's decision, the victim is personally notified. To this end, the RO must have collected several telephone numbers for each victim (including those of other easy-to-reach family members or community leaders authorized by the victim). The RO's pre-scheduled follow-up days – preferably selected based on key days when people in the area gather (e.g., market days, religious holidays, etc.) - must also be planned in each zone and the information (specific dates and locations) communicated to the victims in advance, in a transparent, clear and efficient manner. If it is still impossible to contact certain victims despite all these precautions, the ROs may send field agents directly to the victims' homes to communicate with them, although this solution would be quite exceptional. In the case of a positive decision, an accreditation document must be issued and delivered to the victim.

In addition, "it is necessary to ensure that decisions are made speedily and that an accelerated [review] process is available and planned for rejected cases"[362] In other contexts, the decision

357 Interviews during field missions, *supra* note 108.

358 These tasks mirror those of the Committee responsible for assessment and qualification in the Peruvian process which refers to "preparing an informed technical opinion (context of the case, actions performed, factual and legal analysis and recommendation as to the eligibility of the victim/beneficiary) for each victim (Consejo de Reparaciones, *supra* note 303, art, 40).

359 This procedure is taken from the approval procedure used in Peru (*Ibid., art. 41).*

360 For example, in the Philippines, the Council consisted of 9 members, at least 3 of whom had to be members of the local bar and have practised law for at least 10 years and have knowledge and a marked commitment to human rights protection, promotion and advocacy (Sarmiento, L.C., et al.., *supra* note 300, art. 3.4).

361 *Ibid.*

362 Correa C., *supra* note 70, p. 44.

of the final body was subject to appeal (notably the Philippines[363]), whereas in others, the decision was final. Unfortunately, in the case of large-scale reparations, processing such applications for review in accordance with appeal procedures, when they exist, is often long, costly and administratively burdensome.[364] However, minimal review procedures are essential as a way to mitigate the risks of procedural errors and under-inclusion of victims – particularly the most vulnerable – especially if strong, effective and sufficient mitigation measures were not put in place at an earlier stage in the process.[365] Thus, although review procedures should be kept to a strict minimum by using clear and specific standards for the acceptance of applications for review, it is nonetheless important that there be a review procedure of some sort, if only to ensure the possibility of a remedy in case of a palpable and overriding error in the facts or in the evaluation of the case.[366]

3. DETERMINATION OF THE AMOUNTS AND DISTRIBUTION OF THE ASSISTANCE

Once the decision-making process regarding the person's eligibility as a cholera victim and beneficiary of the program has been defined, it will be necessary to determine and distribute the amounts for which the victims qualify.

3.1 Determining the amount

Regarding determination of the amount itself, it is generally recognized that it must "improve the living conditions of and opportunities for victims so that they can overcome the worst consequences of the violations and achieve the economic and social status of an average family."[367] However, financial constraints are a huge obstacle for most large-scale reparations programs and it is generally agreed that there is no amount that would suffice to fully restore the victims to their previous situation. Thus, these are essentially symbolic amounts[368] intended "to guarantee, at a minimum, the modest survival of those most affected,"[369] but are generally "modest enough not to be a heavy burden on the … budget" of the entity providing the funds.

To arrive at benchmark that corresponds to this acceptable economic standard, a number of criteria may be used based on the socio-economic standards of the country. In this regard, it should be noted that "making an assessment of the individual needs of each victim is not recommended"[370] but an appropriate amount should be determined for each class of victims (death or illness). For example, in Côte d'Ivoire, in order to determine the amount of lifetime pensions, the minimum wage was proposed as a benchmark; on the other hand, in Chile, average household income (adjusted for inflation) was used.[371] In Peru, the amounts were determined arbitrarily and without proper consultation with the victims. This fostered resentment among the victims, and also contributed to certain conflicts.[372]

363 Sarmiento, L.C. et al., *supra* note 300, art. 5.15.

364 According to Cristián Correa, in one case where 35,000 applications were received, 27,000 claims were accepted (a rejection rate of just over 20%). Almost all of the rejected claims were appealed. Thus, the processing of about 8,000 claims in appeal lasted as long as the initial process, in which over 35,000 claims were examined, for an acceptance rate of about 20% or just over 1,500 cases (Interview of Cristián Correa, 2018).

365 In fact, in any process where there is no predefined higher body with a right of review for errors, an application for review "may sometimes be the last chance to obtain justice and ensure that fundamental human rights are respected. This right is so crucial that it can itself be called a fundamental right of citizens" (Vallières, 2005, available at barreau.qc.ca/).

366 Palpable and overriding error is generally the minimum standard used in administrative law for review procedures.

367 Correa, C. *supra* note 70, p. 14.

368 Interview of Cristián Correa, *supra* note 307.

369 Correa, C. and Gbery D., *supra* note 128, p. 7.

370 *Ibid.*, p. 7.

371 REDRESS, *supra* note 91, p. 13.

372 ICTJ, *supra* note 314, p. 15.

In Haiti the minimum daily wage is 400 HTG, which is equivalent to about 8,000 HTG per month or less than US $100 per month. Meanwhile, the average annual income in 2017 was US $760 per annum, or just over US $60 per month.[373] Another possibility, which is probably fairer, considering that the average salary does not cover the minimum cost of living, would be to determine the amounts based on the average loss of the affected households. According to a survey conducted in 2013, the average cost for funerals and burials of cholera victims was US $5,610, medical expenses were US $224 and the average loss of income in case of death was about $525.[374] Regardless of the type of calculation used, given the widespread poverty in Haiti and the high cost of living,[375] these amounts should be paid in several instalments in order to optimize the positive effects on victims.

3.2 Number of instalments and duration of the program

On the matter of the number of instalments to be preferred, it is generally advised to stagger the instalments over time, in the form of a lifetime pension (as was done in most of the above-mentioned comparative examples).[376] The feasibility (particularly in terms of the administrative and financial burden and complexity) of granting a lifetime pension must be considered, however, insofar as the management and monitoring of the program would not depend exclusively on a State agency. Consequently, several instalments over a predetermined long-term period would be the best option in Haiti.[377] This would optimize the transformative potential of the payments, foster better management of the payments by the victims, ensure them better living conditions, take into consideration the fact that the initial harm suffered and its impact is accentuated over time, and limit the risk of theft and fraud involved in using cash amounts.

It has been shown that these payments, even when modest, have had positive long-term effects, particularly where the basic needs of the victims are considerable, as is the case in Haiti. For example, a single payment under a cash transfer program to 550 households in Vietnam reduced poverty rates by 20% in only two years.[378] In Uganda, a similar program targeting economically marginalized women allowed them to double their income and triple their household savings within just one year.[379] In Kenya, this type of program has had positive long-term effects on household consumption, food security, family income and family assets.[380]

Additional analyses of more diverse samples could be useful to more accurately define the terms and conditions for determining and distributing this financial assistance. Nevertheless, the data gathered in this study shows that statistical sampling is a promising avenue for determining the most appropriate amount of assistance, as well as the number of instalments and the duration of the program.[381]

373 World Bank, *GNI per capita, Atlas method (current US$)* (2018) available at: <https://data.worldbank.org/indicator/NY.GNP.PCAP.CD?locations=HT>.

374 REDRESS, *supra* note 91, p. 13.

375 World Bank, *Consumer price index (2010 = 100) – Haiti* (2018) available at: https://data.worldbank.org/indicator/FP.CPI.TOTL?locations=HT&view=chart.

376 Correa C. and Gbery D. *supra* note 128, p. 7.

377 Interview of Cristián Correa, *supra* note 307.

378 Lawson David et al., *What Works for the Poorest? Poverty reduction programmes for the world's extreme poor* (2010), Practical Action, 308.

379 IPA, *Enterprises for Ultra Poor Women After War: The WINGS Program in Northern Uganda* (2012) available at: poverty-action.org <https://www.poverty-action.org/printpdf/6541>.

380 Haushofer, J. and Shapiro, J., *Household Response to Income Changes: Evidence from an Unconditional Cash Transfer Program in Kenya* (November 2013) available at: princeton.edu <http://www.princeton.edu/~joha/publications/Haushofer_Shapiro_UCT_2013.pdf>.

381 *Ibid.*, p. 14.

3.3 Distribution of the amount among family members

In the case of a deceased victim, the distribution of the actual amount among family members who qualify as beneficiaries (See b) Persons qualified to make a claim and to be considered as beneficiaries) also varies from one case to the next. However, it is preferable to determine beforehand how the amount will be allocated among the family members in order to reduce the risk of conflicts (particularly in the case of complex family structures such as exist in Haiti) and to ensure everyone's well-being.[382] For example, in Chile, instead of using a fixed amount and dividing the total among the various members of the family, a fixed percentage reference amount (based on the average family size) was allocated to each class of family member. Thus, the amounts were divided in such a way that 40% was paid to the surviving spouse, 15% (increased to 40% by subsequent legislation) to the parents of children born out of wedlock, 15% to each child under the age of 25, and 30% to the mother of the victim or, failing the mother, the father of the victim.[383] The risk of family conflicts was thus mitigated since the amount received by each family member remained unchanged regardless of the size of the family or the number of persons who claimed compensation, thereby limiting opportunities to exclude one person in order to obtain a larger amount. Although this option is particularly attractive when dealing with complex family structures, the design of the program may become more difficult, especially in terms of budgeting, since technically it enables families to exceed 100% of the initial reference amount, depending on the size and structure of the family.

Although determination of the exact percentages varies considerably from one comparative example to another, this formula, which gives preference to the spouse, then to the parents (with priority to the mother) and finally to the children, appears to be the one preferred in a number of similar contexts.[384] However, in the present case, the victims emphasized that the families who had lost a breadwinner, and children who had experienced marked suffering deserved to be prioritized in the material assistance and support program. Accordingly, based on the victims' expectations and priorities, in the case of a deceased adult, it would be more appropriate to propose a distribution that prioritizes 1) the surviving spouse (who is generally the family breadwinner after the victim's death); 2) the victim's children; and 3) the victim's parents. In the case of the death of a child, it would be appropriate to prioritize the parents of the victim.

382 Interview of Cristián Correa, *supra* note 307.

383 REDRESS, *supra* note 91, p. 13.

384 Interview of Cristián Correa, *supra* note 307.

3.4 Distribution of the amount

Although the victims expressed a preference for direct distribution to the various qualifying family members (particularly for reasons of transparency and fairness in a context of complex family structures), they acknowledged that it would be acceptable to distribute the amount through a family representative if the first option were not possible from an administrative or logistical perspective. Thus, the victims mentioned two possible approaches: either distribution through the family breadwinner, or through the surviving spouse.

While distribution of the amount through a family representative necessarily raises problems in terms of the concentration of decision-making power, when necessary, distribution through the women in a household is a surer solution, in the sense that, compared to men, they would be more likely to invest the amount to maximize the benefits for the family, even in very patriarchal societies.[385] In addition, distributing cash to women appears to have considerable additional advantages. In Zimbabwe, in a program of this sort, both men and women said that such transfers "improved communication between spouses or other family members,"[386] challenging gender stereotypes. In fact, "men started to see that women were capable of managing money and could contribute to discussions on its use." Some men even started consulting their wives on how to spend income from other sources.[387]

Although most men agreed that women should receive these transfers, some of them did not understand (and in some isolated cases, expressed frustration). The Zimbabwe case teaches the importance of dialogue and raising awareness in the communities (especially with the men) on gender issues and the specific objectives of these programs.[388] Thus, if this distribution approach were applied in Haiti it would be essential to organize gender equality awareness workshops in the communities in order to foster the public's understanding of the program.

385 Interview of Cristián Correa, *supra* note 307.

386 Concern Worldwide and Oxfam GB, *Walking the Talk: Cash Transfers and Gender Dynamics* (November 2011). p. 14, available at: https://oxfamilibrary.openrepository.com/bitstream/handle/10546/131869/rr-walking-the-talk-cash-transfers-gender-120511-en.pdf.

387 *Ibid.*

388 *Ibid.*, pp 20-21.

RECOMMENDATIONS

1. In accordance with international human rights standards and the guidelines set out in the UN's *New Approach to Cholera in Haiti,* the UN should ensure that the priorities, needs and concerns of cholera victims are considered and addressed, with particular attention to those of women and girls, when designing and implementing any form of material and financial assistance for them;
2. The UN should develop a mixed approach, including complementary collective and individual assistance components, to address the individualized suffering of cholera victims, to take into account the consequences of cholera for the community and to mitigate the risk of family and community conflicts;
3. As part of the implementation of the individual component, the UN should prioritize as beneficiaries the immediate entourage of people who have died of cholera, in particular women, children, youths and those who have lost a breadwinner in their families; and consider survivors as the second priority group, in particular those who are still living with sequelae of the illness;
4. As part of the implementation of the collective component, the UN should specifically take into account the needs of the victims most affected by cholera, with particular attention to those of women and girls, as well as needs that cannot be targeted by an individual component;
5. The UN should consider the use of symbolic measures to fully recognize the specific suffering of victims and its responsibility for the cholera epidemic in Haiti.
6. To identify cholera victims, the State should develop a database consolidating information held by patient care facilities, and mobilize informal information networks in order to complete and verify existing data, particularly about persons who became ill or died outside of the formal health structures;
7. The UN should set up a simple, rigorous, transparent and inclusive mechanism for a complementary individualized assistance package that is adapted to the contextual realities of the country, including the complexity of family structures, by developing flexible criteria for determining who can be considered a beneficiary;
8. The UN should take into account the limited access to written documents and encourage the use of a combination of physical proof, testimony, contextual information and presumptions to establish victim status;
9. The UN should determine in advance the terms and conditions and the amount payable to each family to help overcome the harmful consequences of cholera;
10. The UN should consult the victims and members of the communities affected by cholera at every stage of the design and implementation of this mechanism, and develop measures to encourage the participation of women and girls and take into consideration their specific needs arising from the gender-specific impact of cholera.

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APPENDICES

APPENDIX 1: MATRIX FROM STUDY ON VICTIMS' POINT OF VIEW

City or towns (rural towns with an*)	# of Focus Groups	# of Participants	# of Interviews
Metropolitan Port-au-Prince (including Pétion-Ville and Carrefour)	6	42	6
Saint-Marc	2	19	3
Mirebalais	2	12	3
La Chapelle*	2	14	2
Anse d'Hainault	1	10	5
Chambellan*	2	14	3
Total	**15**	**97**	**22**

APPENDIX 2: LIST OF QUESTIONS FOR INTERVIEWS ON VICTIMS' POINT OF VIEW

CONTEXTUAL QUESTIONS

- How have you, your family member(s) or community been affected by cholera (e.g., infected by cholera, death in the family, etc.)
- How many people in your family/community were affected by cholera?
- How did you/your community deal with the illness or death (e.g., treatment of illness, burial of deceased)?
- What did you think caused the illness at the time?
- What do you know about cholera now? What was the root cause of it?

GREATEST VICTIMS AND CHOLERA'S IMPACT ON THEIR LIVES

- Who do you believe have been the greatest victims of cholera?
- What has been the impact on their lives?
- In what ways have this group suffered differently or more than others impacted by the epidemic?

UN DIRECT ASSISTANCE TO CHOLERA VICTIMS AND ITS BENEFITS

- UN has issued a report where it suggests providing direct support to cholera victims however it has been reluctant in following through on these approaches. Direct or indirect assistance would be provided to households most affected by cholera, what would such an initiative (an 'individual approach') look like?
- What type of direct or indirect support to cholera victims would most benefit victims?
- What positive impacts would direct assistance likely have on beneficiaries/ beneficiary households?

- Who should be the beneficiaries of an individual approach? Should it be limited to a particular set of victims, in light of the high numbers of people impacted by cholera and funding limitations?
- Who should decide who benefits from direct or indirect support?
- If financial assistance is provided to victims, what methods can be used to identify the victims who should benefit? In what ways should victims be able to establish that they qualify for assistance (e.g., death certificates? Sworn testimony? Should the community / other actors have a role in determining who qualifies for benefits?)? Explain.

FEASIBILITY OF UN DIRECT ASSISTANCE APPROACH

- Which international, national or local body/entity/organization(s) (e.g., UN, GoH, Mayors, CASEC/ASEC, CBOs) should be charged with overseeing/managing such a program (e.g., determining approach to assistance, identifying beneficiaries, determining amount of assistance, etc.)
- Which international, national or local body/entity/organization(s) (e.g., UN, GoH, CBOs) should be charged with implementing such a program (e.g., issuing/administering payments)
- Have there been programs in the past that some but not all in the community benefited from? Did this create conflict in the community?

RISKS ASSOCIATED WITH THE DIRECT ASSISTANCE APPROACH

- What challenges would there be with taking an individual approach (e.g., correctly identifying victims, creating conflict within communities?)
- What are the security risks associated with providing financial assistance? Can individual compensation create/increase resentment/conflict in communities and families?
- How serious is the potential for fraudulent claims?

RISK MITIGATION STRATEGIES FOR THE DIRECT ASSISTANCE APPROACH

- What can be done to mitigate these risks/challenges, if anything?
- Which international, national or local institutions/organizations/entities should play a role in mitigating risks/challenges?
- What type of safeguards can be instituted against fraudulent claims?
- Which international, national or local institutions/organizations/entities should play a role in safeguarding against fraudulent claims?

APPENDIX 3: INTERVIEW SCRIPTS FOR THE FEASIBILITY OF AN INDIVIDUAL APPROACH

1. INTERVIEW SCRIPT REGARDING THE CARE OF VICTIMS IN AN INSTITUTIONAL ENVIRONMENT

1. What specific medical criteria do you use to identify a cholera case? Is this definition centralized and used nationally or does it vary from one treatment centre to another (hospital/communal health centre/CTC/CTU)?
2. How are persons presenting with clinical signs of cholera diagnosed? Do you use a specific test to confirm the diagnosis? If so, is the test carried out systematically or in specific cases (which cases)? Is the diagnosis done differently for adults and children under the age of 5, for example?
3. Is a document showing the diagnosis generally given to patients when they leave the hospital or CTC? What does the document contain?
4. What is the usual procedure for admitting a patient to the hospital or CTC? Is this procedure the same in all hospitals or CTCs?
5. Is there a standard admissions form for admitting patients to hospitals or CTCs? What is on the form? Is it used in all hospitals or CTCs?
6. Are patients asked for certain documents before being admitted to hospitals or CTCs? If so, what are those documents? Are there other requirements for admission?
7. How is patients' data handled? Is there a central registry that records all cases nationally? What information does the registry contain (name, death, treatment received, duration of treatment)? In the case of deaths, is there a specific way of registering the deaths of patients in the hospitals' or CTCs' records?
8. Have you kept information about each individual who attended your facility? In addition to names, does the document contain the address, national identification number and information about the death, treatment received and duration of the treatment, for example?

9. In addition to the patient's name, have you kept the names, addresses and identification numbers of the person(s) who accompanied the patients?
10. In the event of a death, what follow-up do you do? Do you follow up on the issue of the medical certificate and/or the death certificate?
11. If a person who is not accompanied by a family member dies, how do you go about finding their relatives?
12. How does the institution handle data relating to infections and deaths outside the institution? Do you also work with NGOs in centralizing data? Do you have a parallel community system for gathering information? How does it work?
13. In your opinion, what is the extent of the existing documentation in terms of the percentage of victims covered?
14. How is such data subsequently handled and by which agencies? Is the data broken down by age, sex, geographic location and time period?
15. Currently, if you want to trace the identity of a former patient, how do you proceed?
16. Does the information you currently have in your possession allow you to identify victims between 2010 and the present time? At the start of the epidemic, before a centralized documentation system was set up, where did the information concerning the number of institutional and non-institutional victims come from? Did you work in partnership with other institutions or organizations to this end? Were the names of victims also recorded?

2. INTERVIEW SCRIPT FOR MEETINGS WITH VICTIM ORGANIZATIONS

1. What is your role vis-à-vis cholera victims? What kind of accompaniment/support do you provide?
2. Do you operate nationally? In which communes/towns are you active?
3. Do you work with other institutions or civil society organizations? If so, which ones? In which communes/towns are these organizations active?
4. How many members does your organization have? Are there more men or women? Are there specific criteria for a person to join your organization? How do you recruit new members for your organization?
5. Do you require proof of their victim status? If so, what kind of proof do you accept?
6. Among your members, what percentage do you believe have proof of their condition (medical certificates, death certificates or other notarized documents)? In your network, do you have access to professionals (lawyers, notaries) who help you to obtain proofs?
7. Does your organization keep written records of cholera victims and those who died?
8. How do you obtain information on victims who were not treated at a hospital or CTC in the areas where you are active? How do you obtain information about victims who died in the areas where you are active but not at an institution?

9. In your opinion, who should receive compensation 1) in a family where a child contracted cholera and 2) where a family member died of cholera?
10. Do you receive testimony from victims or victims' families? Is it recorded somewhere?
11. What do you think about the issue of compensation for cholera victims? Do you prefer an individual approach, a collective approach or a mixed approach for potential compensation? Why?
12. What are the risks and strengths of each approach in your opinion?
13. Do you think compensation could be a source of conflict in communities and/or in families?
14. What measures would you propose to reduce conflicts in communities and/or in families?

3. INTERVIEW SCRIPT FOR MEETINGS WITH REPARATIONS EXPERTS

1. In your experience, how does a conventional large-scale reparations process work?
2. In other contexts, have you proceeded differently where national institutions were fragile? If so, how did you work around the problem of weak institutions without compromising the government's autonomy?
3. In your experience, what is the process to establish a list of victims who should receive reparations? How did the process of submitting a claim work in other contexts? Did the victims themselves have to make claims and submit proofs or did the reparations process determine proactively who was a victim, or was it a combination of both? In other words, are claims made at the initiative of victims or at the request of an agency?
4. What bodies decided on victims' claims? Were these judicial or extrajudicial processes?
5. How can one ensure that these bodies offer guarantees of transparency? Could you give two or three examples from other contexts?
6. How did you work around the scarcity or absence of documentation to establish proofs, especially proof of the status of victim in certain contexts? To your knowledge, what type of proof is generally used to constitute a file? Do these proofs differ depending on the status of the victim (direct/indirect) or the type of harm suffered? What is the standard of proof generally used to determine whether a claimant is a victim? How is the risk of false victims reduced in other contexts?
7. Are there judicial or administrative review processes for decisions made by the bodies responsible for granting reparations to victims, including to allow victims to contest the rejection of their claim?
8. How are problems of lack of documentation addressed in other contexts? What systems have been used to identify victims? What was the role of formal institutions in identifying and establishing the status of victim?

9. Did you use alternative verification processes? If so, what were they? What problems did these processes avoid? What problems or conflicts did you encounter?
10. Are there any ethical issues that need to be considered in such a compensation program? What are they? How can they be taken into account in the process, when identifying victims, reviewing claims or distributing the compensation?
11. In your experience, how did the context influence the choice between individual or collective compensation? What were the advantages and limitations of this type of compensation in your previous experiences?
12. What modes of distribution of the compensation do you generally prefer? What are the limitations and advantages of each of these two modes?
13. In Haiti, where documents to trace victims are not always available, what would you propose?
14. What are the implications of a compensation process in a context of great economic and social vulnerability? How does that affect community and family cohesion and what are the risks? How can these undesirable effects be avoided as much as possible?
15. How are the risks of intra-community and family conflicts usually mitigated elsewhere? How do you think that could apply specifically in the Haitian context?
16. In a context where the State is more or less absent, what role do you see for victim associations and civil society in such a process in Haiti?

5. INTERVIEW SCRIPT FOR MEETINGS WITH EXPERTS ON THE CHOLERA QUESTION IN HAITI

1. What is your estimate of the total number of cholera victims in Haiti as at today's date (numbers who contracted cholera and numbers who died)? In your opinion, what percentage were treated by the institutional system (CTCs or other health centres)? How reliable is the institutional data? What percentage of victims have documents attesting to their illness?
2. What specific medical criteria are used in Haiti to identify a cholera case? Is this definition centralized and used nationally or does it vary from one treatment centre to another (hospital/communal health centre/CTC/CTU)?
3. How are persons presenting with clinical signs of cholera diagnosed? How reliable is the diagnosis? Do you use a specific test to confirm the diagnosis? If so, is the test carried out systematically or in specific cases (which cases)? Is the diagnosis done differently for adults and children under the age of 5, for example?
4. Is a document showing the diagnosis generally given to patients when they leave the hospital or CTC?
5. In your opinion, which areas were most affected by cholera? What is the reason for this geographic distribution? Which areas have least access to health care?
6. Do you generally visit these communities as part of your practice?

7. For people who did not attend a CTC or another health care establishment, are there avenues that can be explored to show that they actually had cholera?
8. In your opinion, are there post-recovery signs that would prove that the person was infected with cholera? Can cholera symptoms trigger longer-term effects in a previously healthy individual and in an individual suffering from malnutrition?
9. In your practice in the field, with which groups do you usually work who could potentially help to trace victims who did not attend a health care establishment? What other actors could be mobilized for this purpose?
10. How can victims who did not attend a CTC be identified?
11. What do you think of the community alert and surveillance systems that were set up in the field? How reliable are they as an information gathering system?
12. Based on the territorial configuration what endogenous scenario could be used to trace cholera victims who did not attend CTCs or hospitals? Could a different scenario be envisaged for deaths that did not occur at CTCs or other health care establishments?
13. How could the number of "false victims" be limited? Are there other possibilities of community or family conflicts that could arise from the identification process? How could they be limited?
14. How can family and community conflicts be limited if and when compensation is paid? What avenues would you propose to explore to ensure that the compensation is paid to the right people given the complexity of certain family structures? What form do you think compensation should take to have the greatest effects on the life of the victim/his or her family?

6. INTERVIEW SCRIPT FOR MEETINGS WITH LOCAL AUTHORITIES, MEMBERS OF CIVIL SOCIETY AND COMMUNITY LEADERS

1. How did cholera break out in your community?
2. What did you do to address cholera in your community?
3. Did you keep a registry of people who contracted cholera or died from cholera? If not, do you have other ways of identifying them?
4. In general, do you know if a person is a cholera victim? What do you advise the person in that case?
5. Have you developed relationships with CTCs in order to identify the people who contracted cholera or died from cholera? What kind of procedure did you use? What information was recorded (name, address, telephone number, national identification number, etc.)?
6. Can you trace the victims who frequented your (church, organization, etc.,)? If so, how?
7. What did you do to provide social support to the survivors?

8. Do you see a risk of family or community conflicts if compensation is paid? What kinds of conflicts would compensation trigger in the community or among families? Why?
9. What solutions would you propose to mitigate conflicts?
10. Are there local mechanisms that could help to reduce community and family conflicts? If so, what are they and how do they work?
11. Do you have leaders in your community who can help to mitigate the risks of conflict? When are they asked to get involved?
12. Has your community previously benefited from "cash for work" development programs? How do they operate in your community?
13. Have these programs caused conflicts? What kind of conflicts? How have you avoided certain conflicts? What would you recommend to avoid conflicts that were unavoidable in the past?

7. INTERVIEW SCRIPT FOR MEETINGS WITH LEGAL EXPERTS ON INHERITANCE ISSUES

1. In your opinion, what are the main Haitian legislative provisions that apply to inheritance in the case of cholera victims?
2. Who would be eligible to submit a claim for a deceased victim and to pursue judicial remedies? Would it be possible for several people to submit a claim for the same victim based on the same facts?
3. From a procedural perspective, what would be the process for the potential heirs of a person who died of cholera to assert their right to inherit? What documents would they require?
4. What is the value of death certificates to determine inheritance rights of heirs in Haiti? If the potential heirs do not have a death certificate, what other means are available to them?
5. What documents are required to prove the heir's identity or to prove filiation?
6. In the case of compensation of victims who were not treated in an institution, how does one proceed without a medical certificate? What other proofs might be accepted to prove victim status and the various types of harm suffered?
7. In your opinion, from a legal standpoint, which family member should receive compensation in the case of a death?
8. In the case of the death of a child whose parents are separated/divorced, who should receive the compensation?
9. If the inheritance was to be given to the deceased person's wife, how would it be possible to distinguish between different partners?
10. Between a de facto spouse who actually lived with the person during his illness and his lawful wife, who should be given preference to receive compensation?
11. If the inheritance is to pass to the children of the deceased, how should the amount be divided among several children?
12. From a legal standpoint, what elements have to be considered to prevent and manage conflicts relating to compensation?

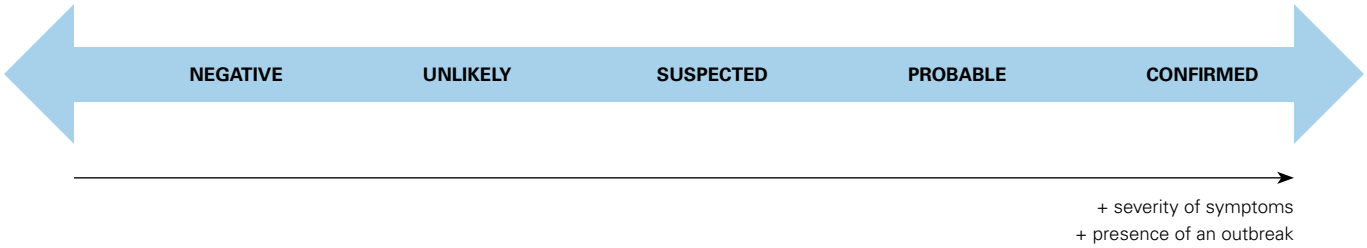
8. INTERVIEW SCRIPT FOR MEETINGS WITH EXPERTS IN CASH TRANSFER PROGRAMS

1. What is your experience of large-scale cash transfer programs? How does such a process typically unfold?
2. In other contexts. have you proceeded differently when national institutions were fragile? If so, how did you work around the problem of weak institutions without compromising the government's autonomy?
3. How do you identify beneficiaries? Do they have to submit certain documents in order to access the programs? If so, what documents? How do you proceed if the victim does not have these documents?
4. What was the respective role of the formal and informal institutions in identifying beneficiaries?
5. How do you proceed when the program does not concern the whole community, but only specific individuals? How do you identify the beneficiaries? How were the risks of fraudulent claims limited in other contexts?
6. How do you proceed to limit the potential for community and family conflicts?
7. How does the context influence your way of proceeding? How would you propose to proceed given the situation in Haiti?
8. How do you recommend adapting these programs to the circumstances? What are the implications of such a program in a context of great social and economic vulnerability? How might that affect community and family cohesion (what are the risks?) How can these undesirable effects be avoided as much as possible?
9. Have you previously managed programs that included inheritance issues? If so, how did that change your way of proceeding?
10. How are the risks of community and family conflicts mitigated elsewhere? How could that apply in the Haitian context?
11. In a context where the State is more or less absent, what role do civil society and community leaders play in establishing and ensuring the sustainability of such programs in Haiti?
12. Are there ethical issues to be considered in the context of such programs? What are they?
13. What situation could be a case of fraud? How can such situations be limited and identified?
14. How does one account for lack of documentation? How does one identify beneficiaries in this context? What experiences and methods used elsewhere do you think could be applicable in this case?

9. INTERVIEW SCRIPT FOR LIFE STORIES

1. What is your name? How old are you?
2. Do you have children? If so, how many? What is your marital status?
3. Are you from Port-au-Prince? If not, where are you from?
4. What do you do for a living?
5. When did you contract cholera?
6. Did you receive treatment at a hospital or CTC? Which one? If not, who cared for you?
7. Do you have a file at the centre? Were you properly registered at the centre with your national identification card or another identity document?
8. Do you have a medical certificate, results of a test, a photocopy of your medical record, photos, or prescriptions for medicine?
9. What kind of expenses did you incur for cholera treatment? How did you pay for these expenses?
10. Who accompanied you during your treatment?
11. How was your recovery? Were you able to return to work without any problems?
12. How did you find out about the cholera victims' group?
13. What document did you provide when you joined the movement?
14. Were you asked to relate your experience as a cholera survivor?
15. What effect has cholera had on your life? Do you believe that life "after cholera" is different from life "before cholera"?
16. What do you know about how cholera came to Haiti?
17. How is your life after cholera? What are the effects of the disease? For example, is there stigmatization?
18. What do you think about the question of compensation?
19. Is it important for you? Why?

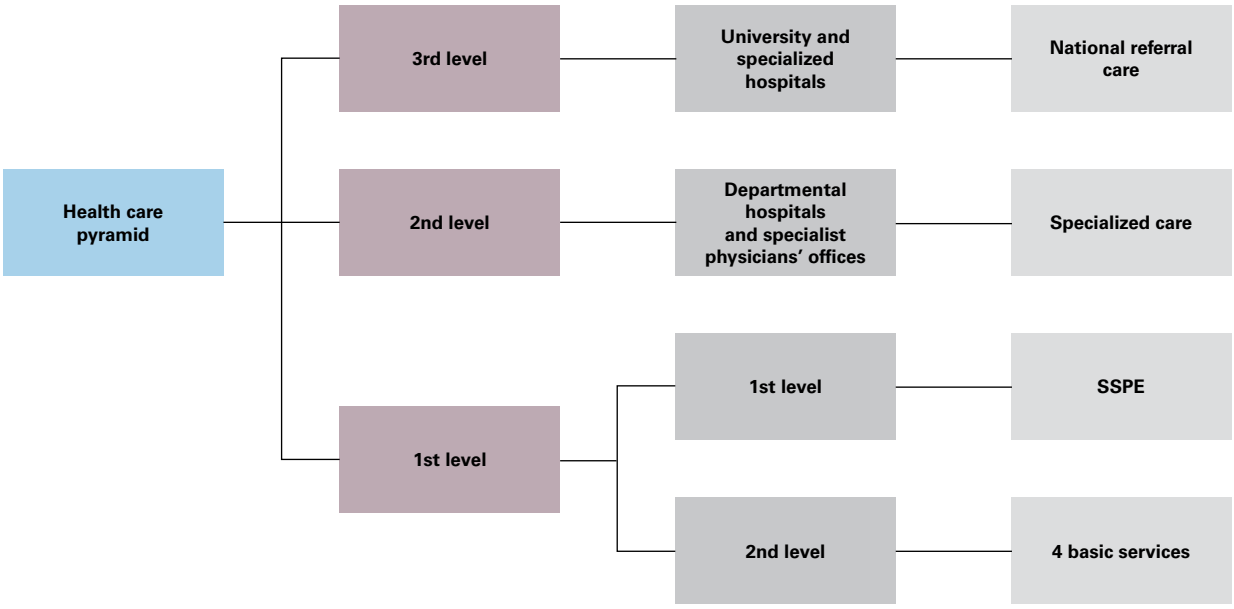
APPENDIX 4: CLASSIFICATION OF TYPES OF CHOLERA CASES



The definitions are as follows:

1. **A probable case:** a person presenting clinical symptoms of cholera during an epidemic or a known outbreak in a given area, or who has been in contact with at least one confirmed case.
2. **A suspected case:** a person presenting typical clinical signs of cholera.
3. **An unlikely case:** any case where the clinical signs do not correspond to cholera, but that has not been shown to be negative by a fecal culture.

APPENDIX 5: ORGANIZATION OF THE HAITIAN HEALTH CARE SYSTEM

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