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Case Report: Two Cases of Restavek-Related Illness: Clinical Implications of Foster Neglect in Haiti

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Abstract. Restaveks, or indentured foster children, are a poorly understood, vulnerable subclass of Haitian society. From 2001 to the present, a partnership between multiple US academic medical centers and Project Medishare for Haiti has held an ongoing series of mobile clinics in rural Haiti. Multiple cases of restavek-related illness were identified. At a recent pair of mobile clinics, the authors identified two restavek cases that were significantly worse off than their communal peer groups and required immediate care. Given the lack of a robust legal support to protect orphaned children in Haiti, clinicians have an important role in advocating for restaveks at the bedside. The plight of Haiti's restaveks is widely reported in the human rights literature but is not publicly recognized as an issue for community health and wellbeing among physicians. To address these health disparities, the health consequences of an entire class of neglected children must be further explored.

INTRODUCTION

The Haitian Kreyol word restavek literally means to stay with. This seemingly benign translation masks the gravity of the label. A child, usually less than 15 years old, is often sent from a poor family to a more affluent household under the pretenses that he or she will have access to a better life. However, in exchange for lodging, restaveks are frequently expected to perform hours of domestic labor and are often subject to physical, emotional, and sexual abuse. These children are frequently overworked, lack adequate nutrition, receive little to no education, and are neglected by the entire community.

From 2001 to the present, a partnership between multiple US academic medical centers and Project Medishare for Haiti has held an ongoing series of mobile clinics in rural communities of Haiti's Plateau Central. These mobile clinics, run by both American and Haitian healthcare workers, provide ongoing primary care services to patients who are too remote to receive services at district hospitals and dispensaries. Two particular clinical cases of restavek neglect were identified in a series of mobile clinics held in November 2009. By describing these cases, we examine the role of the healthcare provider in identifying restaveks, advocating for their rights, and managing the medical consequences of restavek neglect.

Case 1. A 4-year-old female presented to a Medishare clinic with the patient's guardian complaining of the child's overall poor health. She was the last child in a family of three children to be seen. Although the first two children were the biological offspring of the guardian, the third child was not. The guardian claimed that the third child had been eating regularly but had become progressively less engaged. Gathering a complete history became increasingly difficult as the foster mother seemed reluctant to further describe the patient's social status. The medical interpreter noted her concern that the patient was potentially a restavek suffering from neglect.

On physical exam, the patient exhibited limited engagement with both American and Haitian members of the Medishare clinical team. Physical exam findings were significant for reduced affect, poor hygiene, bronzed brittle hair, and dirty clothing relative to her housemates. Her weight-for-height ratio was nearly 2 standard deviations (SD) below the mean.[1] Importantly, the other two children in the household did not have any of the above physical exam findings and had a substantially superior general appearance. The patient was found to be anemic (Hb = 10.3 g/dL) and acutely malnourished; she was treated with oral iron therapy and referred to a centralized child nutrition center for caloric supplementation.

Case 2. A 4-month-old female was triaged at a Medishare mobile clinic after being brought by her 15-year-old mother who reported a 2-week history of decreased responsiveness, vomiting, diarrhea, fever, and weight loss.

After a normal vaginal delivery, the patient was breastfed for the 1.5 months, at which time the mother was told to stop because of her HIV-positive status. Without adequate counseling and follow-up, the patient ceased feeding her daughter breast milk, replacing it with juice, mashed beans, and water.

On physical exam, the patient was listless, lethargic, and febrile (38.4°C). At 4.7 kg, the patient was greater than 3 SDs below the weight-for-length ratio for her age, indicating severe acute malnutrition that was further exemplified by her physical exam findings of body mass wasting.[1] The patient showed signs of severe dehydration with a depressed fontanelle, pale sclera, and dry mucous membranes.

Throughout the clinic visit, the mother remained very quiet and kept a downward gaze. A more detailed social history illuminated the many struggles this young family was facing. The mother was orphaned as a child and had been sexually abused, homeless, and a recurrent target of theft through a series of neglectful, transient legal guardians. The medical interpreter working identified the mother as a restavek whose social status contributed to trouble accessing care for her child. Oral hydration therapy and antibiotics were started on site for the infant. Because of the child's complex medical problems, mother and child were transported to the Partners in Health hospital at Cange, where a maternal HIV program was provided for the mother.

DISCUSSION

Restaveks are a nationwide phenomenon in Haiti. A national door-to-door survey of 1,458 urban Haitian households estimated there to be 225,000 restaveks in the country, two-thirds of whom are girls.[2] The gender differential is important to note, because other social gender biases further

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exaggerate this disparity. Although there are more female restaveks, a larger number of beds in orphanages are open to males. Given that this survey specifically described only those who were officially referred to as restaveks by guardians, it is widely assumed that the actual number of restaveks and restavek-like boarders is much higher.[2]

The restavek labor exchange consists of 10- to 14-hour workdays, for which the child receives no monetary compensation.[3] Psychological, physical, and sexual abuse of restaveks is common. Not only do restaveks suffer acutely, but many of the social disparities result in chronic deficits in quality of life. As seen in both of the cases described here, restaveks often receive inferior nutrition and schooling compared with their peers in the family.[4]

A number of government and human rights groups have begun to address the plight of restaveks, but these groups are far from establishing a solution. Poverty and lack of resources are often cited to justify the persistence of restavek status in Haitian society.[4] The few steps that have been made include the Haitian government's ratification of the United Nations Convention on the Rights of the Child (CRC) in December of 1994, followed by the establishment of a governmental hotline known as SOS Timoun in 2002.[5] The effectiveness of these measures has been limited, perhaps because of lack of political support and enforcement. For example, ratification of the CRC obliges a report every 5 years that discusses actions taken to achieve its goals. However, the Haitian government was more than 3 years late in submitting its first report—a meager document that faulted lack of resources rather than societal neglect. The report also diminished the pervasive nature of restaveks by referring to restaveks euphemistically as enfants en domesticité (children in domestic service). McCalla[4] notes that even leading human rights groups in Haiti as well as Haitian health organizations have remained absent from restavek advocacy.[4] The medical and psychological implications of being a restavek have received even less attention.

The earthquake of January 12, 2010, has increased international attention for Haiti, and the popular press has seized on Haitian restaveks and orphans as a particularly vulnerable social underclass. Over 1 million people have been displaced by this natural disaster, many of whom are children separated from their families among the rubble.[6] If not protected appropriately, these children may be targeted for inclusion in the restavek system. Early steps by the government, however, suggest that its active role in child protection during relief efforts may actually improve the condition of restaveks, because their status has become more difficult to ignore.[6] In the absence of large-scale structural change, clinicians may have an important role in advocating for restaveks at the bedside.

In both of the above cases, two important indicators of restavek status became apparent. First, each of the cases included unreliable historians. Second, both patients presented were relatively worse off than their housemates or local peer group. Both of these themes may be sensitive signs of a potential restavek, and they decrease the likelihood that such patients are solely the result of the rural poverty seen across much of Haiti. Identifying these cases is the first step to treating the health-related outcomes of the condition.

Project Medishare advocates for a multidisciplinary approach to treating restavek-related illness. This strategy would incorporate social workers, nurses, and community health agents, with overall coordination by a Haitian physician, who all understand the cultural context of the restavek system. A limitation of these recommendations is the poor evidence base for restavek-related illness within the medical literature. The plight of Haiti's restaveks is widely reported in the human rights literature but is not publicly recognized as a Haitian issue for community health and wellbeing among physicians. McCalla[4] and the National Coalition for Haitian Rights advocate for direct engagement of restavek households to remove the social acceptance of the practice.[4] There is a dearth of clinical knowledge, however, for how best to provide for the medical needs of this poorly served underclass. To address these health disparities, the health consequences of being labeled a restavek must be further explored. Specifically, further research is required to describe the health impact of this systematized social condition. Important overarching questions include: what is the aggregate effect on public health caused by the restavek system? Also, what is the burden of disease among restaveks, and how does it compare with the general population? The Pan American Development Foundation has recommended that better understanding of this burden of disease—specifically, sexually transmitted infection and long-term psychiatric effects—plays a central role in addressing the restavek system.[2] Clinicians play a major role in addressing this health burden and also engaging with the advocacy efforts to end this social ill.

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