No Time for Poverty Project

Humphrey School of Public Affairs

PA 8081-009

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December 11th, 2012

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Executive Summary

No Time for Poverty is a non-government organization (NGO) working in Port Salut Haiti, based out of St. Paul Minnesota. The founders, Michele and Jeff Boston, also are the founders and owners of Boston Health Care Systems in St. Paul, which provides superior services to individuals with disabilities throughout the Twin Cites metro area.

The Boston's created No Time for Poverty (NTFP), after their first visit to Port Salut, Haiti in September 2005 based on their professional expertise in healthcare with one major objective: *To save lives of suffering and dying children in the region of Port Salut by reducing infant, child, and adolescent suffering with the implementation of a high quality comprehensive community based health system where no child is turned away for an inability to pay.*

The foundation of their work is based on previous experiences of other organizations like Partners in Health or Haitian Health Foundation, which also provide comprehensive health services in communities without discriminating people for their inability to pay.

Why Haiti? Although just 600 miles off the coast of Florida, Haiti's history is plagued with multiple humanitarian crises which stem from reoccurring violence and a long history of socio-economic challenges. Some of these crises include endemic poverty, chronic malnutrition, weak or no access to health care systems, low literacy rates, limited access to food and water, sanitation and other basic services. In January 2010 Haiti suffered a terrible earthquake that only magnified the situation of the country, where socio-economic indicators are among the lowest in the world.

NTFP has sought advice from the University of Minnesota (UMN) in different ways to optimize their activities and performance in Haiti. In 2010 the UMN School of Public Health completed a public health survey with the purpose of providing a baseline level of knowledge, attitudes and practices regarding health care practices of mothers of young children in the five localities selected for their public health care outreach program. In 2011 NTFP engaged in a capstone project with the Humphrey School of Public Affairs to help the organization enhance their processes and make the organization more sustainable and financially healthy in the long term. Our capstone team, consisting of Erica Schneekloth and Dario Kañevsky, Master of Public Affairs candidates, has been assigned to this project. Mr. Kañevsky and Ms. Schneekloth will be referred to as the NTFP capstone team throughout this document.

The work of the NTFP capstone team began in January 2012 and was first initiated by researching and providing an organizational assessment of NTFP. The objective of this initial research was to understand the needs of NTFP beyond their original intentions for their project and mission. This assignment required that the NTFP capstone team perform assessments on the conditions in Haiti, the history of NTFP, their activities, challenges and future needs. The first conclusion from our assessment was that NTFP would benefit from a formal assessment of their overall programs, this research also includes an organizational revision. The NTFP capstone team observed that this research would provide a formal structure of their programs

and activities. This would in turn allow NTFP to continue their research, and begin operating as a professional organization with programs, objectives, budgets and clear documentation.

The NTFP capstone team divided our final presentation in three different documents: the Executive Summary, which includes, a description of the assessments performed and a summary of the recommendations to the organization. The second document prepared for our client is an "Organizational Profile" with descriptions of the actual conditions in Haiti, descriptions of NTFP activities and programs, challenges faced by the organization, the actual Program Evaluation approach and the financial information including the fundraising strategy. Finally, a third section with the recommendations and conclusions, which includes The NTFP capstone team's assessment, interviews with NTFP and other stakeholders doing health care programs in Haiti, and the research and lectures that we did for this project.

The second document, begins with an "Assessment on Haiti Conditions", where our team examined the actual conditions of Haiti using reports from the United Nations and current descriptions from NTFP about their experience in Port Salut, Haiti. In the mentioned reports, The United Nations states the earthquake which hit Haiti on January 12 2010 affected almost 3.5 million people, which includes the entire population in 2.8 million, living in Port-au-Prince. The government of Haiti estimates that earthquake killed 222,570 and injured another 300,572 people. Displacement peaked close to 2.3 million people including 302,000 children. The earthquake of January 12th, 2010 was also complicated by an outbreak of cholera, and within 10 weeks the outbreak had spread to all 10 of Haiti departments. This outbreak caused 5,899 deaths, and left thousands more injured and needing medical treatment. NTFP partnered with the University of Minnesota's School of Public Health and created a survey post the earthquake. This research clearly expressed the need of improvements in the areas of immunization rates, children nutrition, prenatal care, breastfeeding and community health outreach.

The next objective the NTFP capstone team implemented was the amalgamation of extensive research and documentation to provide a concise and specific reference document of their mission, objectives. This document is referred to as the "Organizational Profile". The "Organizational Profile" includes descriptions of NTFP and their program's in Port Salut including the "Klinik Timoun Nou Yo", which is translates to "Our Children's Clinic", which opened November 19th, 2012. The NTFP capstone team deemed it essential to create and organize NTFP's program descriptions, as they will need documentation of their programs, partnerships, financial information and challenges to professionalize their activities. This is fundamental for the success of NTFP as they open the clinic in November 2012. Having this research readily available with the recent opening of the clinic, will allow NTFP to become more independent from its founders and create the framework of their work. In addition the documentation of each program, created by the NTFP capstone team can be extracted for any request of funding, including grant applications or applied in their fundraising strategy. The other programs described in this section include the community Outreach Program, the breast-feeding program and maternal health program.

The fourth section is a description of the partnership relationships built by NTFP and other NGOs working in Haiti. These include, Partners in Health, Haitian Health Foundation, Institute Brenda Stafford, St. Damien Hospital, Hospital Sister's Mission Outreach, Catholic Relief Services, University of Minnesota, Caris Foundation, Vitamin Angels, COFHED, Columbia University. As stated in our recommendations, "We believe that it is especially crucial during the first few years of Klink Timoun Nou Yo to maximize these relationships for collaboration and sustainability. In the long term these relationships will be key to sustain the organization, make it a financially healthy endeavor and a long lasting initiative." (NTFP Capstone Team pg. 65).

The fifth section, the NTFP capstone team created is a description and initial recommendations to create a strategic agenda. Some key points which are included in this section are possible initial challenges the NFTP may need to address and evaluate further, especially during the recent opening of the clinic and in launching their programs. In collaboration with NTFP we have identified six challenges and six proposals to solve them from the organization. These challenges include financial issues, inability to predict the numbers of patients to be served, crowd control, lack of skilled nurses trained in triage, limited referral sources, and "competition" with traditional healers. The NTFP capstone team strongly encourages NTFP to continuously review their organizational objectives and identify the barriers, which they may face in trying to achieve them. The environment where they will operate, including the continuous changes in the structure of Haiti, as well as the typical dynamics faced by the NGO's make this exercise vital for the long term success of NTFP.

In the Program Evaluation section 6 of the profile, the NTFP capstone team describes the continual need for evaluation of NTFP programs. This will be paramount in their programs and deemed critical in reducing infant, child, and adolescent mortality in the region of Port Salut, NTFP defines their evaluation proposal as "data driven". By this they refer to two primary things: Monitoring and evaluation. In this regard, evaluation of the effectiveness of all programs will be measured by outcome based assessments with the capstone team assisting and supporting NTFP in this process. The NTFP capstone team bases this research from interviews with institutions like USAID and other subject matter experts in this area like Brian Foster, Owner and Founder of Insight Enterprise Consulting, whom has extensive experience with USAID grants. This research concludes that in addition to a system of record keeping, establishing a defined set of Measures of Success or Key Performance Indicators, which can easily monitor program performance and evaluate the level of advance in their main objectives. In establishing these metrics, NTFP will be creating short and long term goals for each of their programs in order to achieve their long-term objectives.

In the last section of the profile, the NTFP capstone team has included a description of the financial information for NTFP. This section includes a current budget and also desired projections for the next five years (with information provided by Michelle and Jeff Boston). The NTFP capstone team has also documented the fundraising strategy as it stated today by the founders of NTFP and its evolution. In our recommendations we have added a complete section with complementary actions that we evaluate as essential for this strategy including an agenda

and template of fundraising sources, activities to be pursued and reports to stakeholders about these efforts.

The NTFP capstone team completed our research with our **Recommendations and Conclusions**. This research is based on the work described in the previous paragraphs. As NTFP concludes, their primary focus is to obtain significant funding and to become independently funded by 2017-2018. The NTFP capstone team has identified and outlined a strategy for NFTP to implement and adjust as their programs open and expand as our first set of recommendations to our client. Some recommendations include adding additional staff, including a development director. We believe this is crucial to their organization. This individual should be well versed in writing grants and have experience with USAID funding.

In addition the NTFP capstone team recommends that NTFP identify their expected funding channels and sources. In addition, the NFTP capstone team created an outline of all funding channels with both monetary and in-kind donations. We have recommended NTFP use the "Program Descriptions" created as part of the Organizational Profile as grant templates for NTFP so that they may easily apply for funding opportunities with foundations as they arise, and also prior to hiring additional staff.

Since it is has been determined that NTFP would like to obtain significant funding, it will be crucial for NTFP to work closely with their partners in Haiti to establish partnerships for potential opportunities to receive a sub-grant from organizations that are already receiving USAID funding as it was recommended in interviews with the UMN Humphrey School Professor, Chavanne Peercy and subject expert, Brian Foster both well versed in the USAID grant process.

The second set of recommendations determined by the NTFP capstone team, relates to the professionalization of NTFP. More specifically, our research indicates that in order to become sustainable in the long term without the continuous support of their founders, NTFP has to develop a hierarchal division in accordance with roles and responsibilities. Second, is the Institutionalization of a formal organizational chart with clear definitions of roles, responsibilities and reporting lines. Third is the definition of a corporate budget with allocations and funds by area and different initiatives. Fourth the creation of a clear set of rules and guidelines that will define the behavior and help to build the culture of the organization.

The third set of recommendations is in order to transform their initiative as a sustainable and long lasting organization; it is recommended that NTFP develop a partnership strategy with a long-term vision in order to transform this initiative in a sustainable and long lasting organization. Recognizing that NTFP cannot live in isolation and collaborating with other institution will be instrumental in their long-term development strategy. This will be challenging for NTFP, as many of the organizations they will be partnering with will also and be competing for the same resources. However, the NTFP capstone team considers this recommendation vital for the survival and success of NTFP and their programs. We recommend NTFP to create this strategy as soon as possible to sustain their objectives and begin to create and increase these partnerships.

The 4th set of recommendations includes the need to implement a Program Evaluation methodology beyond a record keeping system. This will require the creation of Key Performance Indicators that can easily describe and monitor the performance of the organization. These metrics are required for all institutions that provide grants, like USAID, and their addition to the program descriptions will be essential in obtaining these funds.

Finally the 5th set of recommendations suggests the implementation and use of management tools in their activities. These are essential in managing limited resources in which they need to achieve their goals and objectives. All of the recommended tools will significantly help NTFP in their decision processes and how to better organize their activities.

The NTFP capstone team has also added an appendix with documentation that we consider vital to anyone engaged with this organization and aspiring to work with NTFP's increased performance. Also included in the appendix is the community needs assessment survey performed by the School of Public Affairs of the University of Minnesota in 2010.

As Humphrey MPA students and new practitioners in this field, the NTFP capstone team would like to congratulate the founders of No Time For Poverty for their work and extraordinary achievements. Throughout our research, we found ourselves deeply engaged with NTFP's objectives and we have become admirers of their work. We strongly believe in their cause and find their objectives compelling to help the communities where they work is applied to be in a better shape.. Our team is grateful to the Humphrey School of Public Affairs and No time For Poverty for letting us participate in this project.

Our recommendations are based on extensive research with interviewing No Time For Poverty and other stakeholders. These recommendations are complementary of the magnificent work that NTFP has done and by no means can replace the magnitude of work incurred in the construction of the clinic and the ideation of the programs that will be implemented in Port Salut, Haiti. However we hope that these recommendations will be an additional grain of sand in the construction, creation and implementation of Klinik Timon No You and its programs. We would be most grateful if NTFP was able to implement our research and assist in the achievement of their objectives.

Organizational Profile

This document called "Organizational Profile" has the intention of being used by the organization in different ways. It can be used as a description of the actual organization with detailed description of all the programs and other aspects that are fundamental to run No Time for Poverty (NTFP), as well that can be used individually section by section. The Organizational Profile includes descriptions of the actual conditions in Haiti, descriptions of NTFP activities and programs, challenges faced by the organization, the actual Program Evaluation approach and the financial information including the Fundraising Strategy.

In the "Assessment on Haiti Conditions", our team examined the actual conditions of Haiti using reports from the United Nations and current descriptions from NTFP about their experience in Port Salut, Haiti. Following the assessment, the next objective that the NTFP capstone team implemented was the amalgamation of an extensive research and documentation of NTFP to provide a concise and specific reference document of NTFP mission, objectives and history. The following section is the "Programs and Activities Description" which includes descriptions of NTFP and their programs in Port Salut including the "Klinik Timoun Nou Yo", which is translates to "Our Children's Clinic", scheduled to open November 19th, 2012. The NTFP capstone team deemed it essential to create and organize NTFP's program descriptions, as they will need documentation of their programs, partnerships, financial information and challenges to professionalize their activities. This is fundamental for the success of NTFP as they open the clinic in November 2012. Having this research readily available will open the opening of the clinic, will allow NTFP to become more independent from its founders and create the framework of their work. In addition the documentation of each program, created by the NTFP capstone team can be extracted for any request of funding, including grant or applied in their Fundraising Strategy. The other programs described in this section include the community Outreach Program, the breast-feeding program and maternal health program.

The fifth section is a description of the partnership relationships built by NTFP and other NGOs working in Haiti. These include, Partners in Health, Haitian Health Foundation, Institute Brenda Stafford, St. Damien Hospital, Hospital Sister's Mission Outreach, Catholic Relief Services, University of Minnesota, Caris Foundation, Vitamin Angels, COFHED, Columbia University. As stated in our recommendations, "We believe that it is especially crucial during the first few years of Klink Timoun Nou Yo to maximize these relationships for collaboration and sustainability.

In the sixth section, the NTFP Capstone Research Team created is a description and initial recommendations to create a strategic agenda. Some key points which are included in the section are possible initial challenges the NFTP may need to address and evaluate further, during the opening of the clinic and launching their programs. In collaboration with NTFP we have identified six challenges and six proposals to solve them from the organization. These challenges include financial issues, inability to predict the numbers of patients to be served, crowd control, lack of skilled nurses trained in triage, limited referral sources, and "competition" with traditional healers. The NTFP capstone team strongly encourages NTFP to continuously review their organizational objectives and identify the barriers, which they may face in trying to achieve them. The environment where they will operate, including the

continuous changes in the juncture of Haiti, as well as the typical dynamics faced by the NGO's make this exercise vital for the long term success of NTFP.

In the Program Evaluation, section 7 of the profile, the NTFP capstone team describes the continual need for evaluation of NTFP programs. This will be paramount in their programs and deemed critical in reducing the infant, child, and adolescent mortality in the region of Port Salut, NTFP defines their evaluation proposal as "data driven". By this they refer to two primary things: Monitoring and valuation. In this regard, evaluation of the effectiveness of all programs will be measured by outcome-based assessments with the Capstone Team assisting and supporting NTFP in this process. The NTFP capstone team bases this research from interviews with institutions like USAID and other subject matter experts in this area like Brian Foster, Owner and Founder of Insight Enterprise Consulting, whom has extensive experience with USAID grants. This research concluded that in addition to a system of record keeping, establishing a defined set of Measures of Success or Key Performance Indicators, which can easily monitor program performance and evaluate the level of advance in their main objectives. In establishing these metrics, NTFP will be creating short and long term goals for each of their programs in order to achieve their long-term objectives.

In the last section of the profile, the NTFP capstone team has included a description of the financial information for NTFP. This section includes a current budget and also desired projections for the next five years (with information provided by Michelle and Jeff Boston). The NTFP capstone teams has also documented the Fundraising Strategy as it stated today by the founders of NTFP and its evolution. In our recommendations we have added a complete section with complementary actions that we evaluate essential for this strategy including an agenda and template of fundraising sources, activities to be pursued and reports to stakeholders about these efforts.

Assessment on Haiti Conditions

The republic of Haiti is a country that shares the Caribbean island of Hispaniola with the Dominican Republic. Haiti is located just 600 miles off the coast of Florida – only 90 minutes by air. Situated on the western one-third of Hispaniola, Haiti encompasses 10,714 square miles – slightly smaller than the state of Maryland. Its population is estimated to be almost 10 million with 70 percent of Haitians living in rural areas.

International health and population experts devised a "human suffering index" by examining several measures of human welfare ranging from life expectancy to political freedom. Only one of them, Haiti, was located in the western hemisphere. In only three countries was suffering judged to be more extreme than that endured in Haiti, and each of these three countries were in the midst of civil war.

In their report of September 2011 about *"Humanitarian assistance, emergency relief, rehabilitation, recovery and reconstruction in response to the humanitarian emergency in Haiti, including the devastating effects of the earthquake"* (United Nations A/66/332 2011) the Secretary-General reported the following:

1. *The earthquake that hit Haiti on 12 January 2010 affected almost 3.5 million people, including the entire population of 2.8 million people living in Port-au- Prince. The Government of Haiti estimates that the earthquake killed 222,570 and injured another 300,572 people. Displacement peaked at close to 2.3 million people, including 302,000 children. At least 188,383 houses were badly damaged and the earthquake destroyed 105,000. Sixty per cent of Government and administrative buildings, 80 per cent of schools in Port-au-Prince and 60 per cent of schools in the South and West Departments were destroyed or damaged. Total earthquake-related loss is estimated at $7.8 billion, equivalent to more than 120 per cent of Haiti's 2009 gross domestic product.*
2. *The earthquake response was complicated by an outbreak of cholera, which was confirmed on 21 October 2010 in the rural Artibonite Department. Within 10 weeks, the outbreak had spread to all 10 of Haiti's departments. As of 10 July 2011, 5,899 deaths had been reported, with thousands more individuals requiring medical treatment.*
3. *On 5 November 2010, Haiti was hit by Hurricane Tomas, which swept across the west of the country. The hurricane caused extensive flooding and the death of six people.*
4. *Haiti's history is plagued by serious humanitarian crises, stemming from recurrent waves of violence against a background of structural socio-economic challenges, including endemic poverty, chronic malnutrition, weak health systems, low literacy rates and limited access to clean water, sanitation and other basic services. Hundreds of thousands of people have been doubly affected by the earthquake's aftermath and the cholera epidemic, with large numbers of Haitians still dependent on assistance for their basic survival. The country continues to face significant humanitarian challenges, including regular exposure to natural disaster risks.*
5. *Humanitarian aid is only part of the essential response required for Haiti, where socio-economic indicators prior to the 12 January earthquake were among the lowest in the world. Long-term recovery challenges are massive and require large- scale investment to spark socio-economic recovery, including in the energy and infrastructure sectors. In addition, it is necessary to rebuild housing, revitalize urban planning to reconstitute destroyed communities and develop new communities. The private sector requires*

additional capital to facilitate investment in microcredit and small- and medium-sized businesses. There is also a need to strengthen governance and the rule of law, create greater transparency in public markets and improve customs and taxation operations.11-48576

6. *As of the end of July 2011, only 37.8 per cent of the funding pledged at the 2010 international donors' conference, held in New York, had been disbursed. Additional financial support for Haiti's recovery is essential.*
7. *During the reporting period, humanitarian assistance was provided to individuals, families and communities affected by the earthquake and cholera crises. Underlying structural poverty, insecurity, political instability and recurrent natural disasters faced by the Haitian people remain serious challenges.*

Later in their report the United Nations Secretary-General refers to the health conditions in the island:

21. *Although relief assistance sustained millions of people during the critical emergency phase, longer-term solutions are desperately needed. At the same time, Haiti faces significant development challenges, including stark disparities between urban and rural areas and uneven distribution of wealth. With 86 deaths per 1,000 live births, Haiti has the highest under-five mortality rate in the region. Less than 40 per cent of Haitians have access to health care and less than 60 per cent of children are immunized for measles. More than 3.7 million people do not have access to safe drinking water. Only 17 per cent of the urban and 10 per cent of rural populations have access to sanitation, leaving 8.2 million persons without reliable access to latrines or toilets. Poor availability and quality of education has translated into only half of school-aged children benefiting from regular education.*
30. *Serious gaps in Haiti's basic service coverage, in particular water and sanitation systems, mean that cholera outbreaks are likely to reoccur. Longer-term behavior change and the addressing of disparities between urban and rural areas are needed and will require sustained investment in social mobilization and the integration of health and hygiene education into relevant curricula for children as well as adults. Continued support for the Government's decentralization policy should remain a priority, as it aims to align services and investments in order to address the gaps and disparities that expose rural communities to higher outbreak risks.*

Children in Haiti die at a rate that astounds foreign practitioners and interested persons from developed nations alike. The major causes of morbidity and mortality of Haitian children are related to lack of appropriate food for growth and development. Chronic malnutrition, coupled with pneumonia, diarrhea and vaccine-preventable childhood diseases are the primary killers of infants and children under the age of five. Recent statistics indicate that one out of every eight children in Haiti die before their fifth birthday.

No Time For Poverty first visited Port Salut, Haiti in September 2005. It became apparent at that time that a comprehensive pediatric medical program was paramount to reducing the infant, child, and adolescent mortality in the region. A number of considerations were deemed critical in achieving this goal.

1. Learn about Haiti's political structures. Towards this end, No Time For Poverty (NTFP) met with government officials including President Andre Preval and then Prime Minister Alexis

2. Learn about Haiti's health system. NTFP visited various private and public hospitals in Port au Prince and Les Cayes; then they met with Haiti's then Minister of Health and cabinet. NTFP formed a relationship with Partners in Health. PIH, under the direction of Dr. Paul Farmer, is in the forefront of providing medical care in Haiti and other developing countries. PIH has been integral to the success of our work in Haiti thus far. NTFP also formed relations with other health NGO's working in Haiti including Catholic Relief Services, Institute Brenda Strafford, St. Damien's Hospital, and the Haitian Health Foundation.

3. NTFP developed intimate relationships with all strata of persons in Port Salut, from peasants (meaning "country dwellers") to local merchants and bourgeois.

4. NTFP established a presence in Port Salut. To achieve this, they did a number of things: purchase a house in Port Salut which they named Kay Espwa (Hope House), and converted it for use as a guest house for No Time For Poverty visitors and other visiting groups doing service in the area. NTFP established a helping presence in the community and distributed rice and beans to a number of communities; NTFP established a program whereby select individuals and family received monthly food allotments; they also adopted an elementary school in a nearby village and provided food and study for 222 students; in addition NTFP built a bread house for the area's primary bread maker in exchange for thousands of rolls distributed to a nearby primary school over a two year period. Finally NTFP provided for corrective surgery for several local children suffering from physical deformities.

5. NTFP developed an intimate working relationship with the Peasant Movement of Port Salut (MPPS) and its leader, Jules Felix. The MPPS is community organized, self-regulated, and aimed at developing and implementing local small level community projects. This organization has been absolutely critical to developing their community partnerships and projects.

6. NTFP conducted a Participatory Appraisal of Port Salut to acquire information helpful to preliminary planning and development of their comprehensive health program. The participatory appraisal resulted from observation, discussion of various individuals, and especially the MPPS.

7. In late 2009, NTFP instituted the first comprehensive, valid and reliable health census in the five localities selected by the community to participate in KTNY's Community Outreach Program. The MPPS criteria for selection included: poverty level, degree of isolation, and greatest numbers of children appearing sick and malnourished. The purpose of the census was to gain information to direct planning and development; gain baseline information for measuring the success of protocols and practices; involve the community in learning about itself, its families, and children; discover major health needs of the community's children,

located those children (and families) with the greatest health needs, provide yet another opportunity for the community to be thinking and talking about health, and engaged the community in the process of establishing its community based outreach program for children. Census takers were chosen by MPPS and lived in the community in which the census would be taken. A stipend was paid to census takers for travel and food expenses in addition to a reasonable wage. Census takers were made aware that a portion of their time was personal contribution to aid in bringing a health program to their community. Census results were compiled and reviewed by the University of Minnesota.

8. Having begun the design process in 2007, final renderings of Klinik Timoun Nou Yo took shape by early 2008. By 2009, No Time For Poverty had is High Impact Panels in country – one year prior to the devastating 2010 earthquake. Built with these panels, the clinic is expected to withstand hurricanes and earthquakes beyond the force of any likely to occur. Its framed roof, unlike any in Haiti, is a mastery of design, built of complex steel trusses interacting with one another to provide a strength and durability equal only to the impenetrable structure of its walls. Construction of KTNY has been a collaboration between Haitian and American contractors and laborers, working side by side, exchanging not only skill and "know how," but ideas, culture, and customs. The expected opening date is September 2012.

No Time For Poverty
(In their own words – Website information)

No Time For Poverty
History

September 2005	First visit to Haiti.
September 2005 to 2008	NTFP provides primary education to 222 children attending Coeur School
September 2005 to May 2011	Education and living expenses are provided for three medical students, a nurse, a dentist, an engineer, and two masonry students in Haiti in exchange for service to KTNY.
November 2005	NTFP launches its food distribution program providing food to needy families in Port Salut and surrounding regions.
January 2006	A bread storage facility is built for a local bread maker in exchange for 9,000 rolls to feed primary school children.
August 2006	Meetings with President Rene' Preval, (former) Prime Minister Jacque-Edouard Alexis and Minister of Health, Dr. Robert Auguste.
January - July 2007	A large home near the clinic site is purchased, renovated and furnished. Kay Espwa (Kreyol for Hope House) frequently houses ten to twelve guests including medical groups serving the Port Salut region.
January 2007	A previously-owned sports utility vehicle is purchased.
February 2007	A large storage facility is built in Port Salut to house supplies and equipment.
July 2007	A meeting with the Mayor of Port Salut and other local officials (first of many such meetings).
September 2007	Documentation required for building Klinik Timoun Nou Yo is completed and submitted to proper authorities.
November 2007	5.5 acres of land is purchased in Port Salut for the construction of KTNY.
January 2008	Architectural plans and renderings are drafted.
March 2008	Hospital Sisters Mission Outreach of Springfield, Illinois, commits to providing KTNY with medical equipment and supplies.
April 2008	A dinner gala with live and silent auction is held in Minneapolis/St. Paul, netting $73,000.
June 2008	EirGen Pharma, Ltd., a pharmaceutical corporation based in Ireland, commits to donating and shipping some of KTNY's most needed medications.
September 2008	The first shipment of medication from EirGen Pharma, Ltd. arrives in Haiti.

NTFP History Continued...

October 2008	Our nursing student graduates.
December 2008	A formal partnership is established with World Wide Village for it to assume primary responsibility for Coeur School in 2009, enabling No Time For Poverty to focus on its comprehensive medical program.
January – February 2009	NTFP repairs and replaces the roofs of homes destroyed in hurricanes.
February 2009	Final architectural plans are rendered. High Impact Panels from Trinidad are purchased and shipped to Haiti for construction of Klinik Timoun Nou Yo.
May 2009	Volunteer mobile medical team travels to Port Salut. No Time For Poverty's two masonry students graduate.
June 2009	June 09 Klinik Timoun Nou Yo construction begins.
September 2009	Second volunteer mobile medical team travels to Port Salut.
October 2009	A dinner gala with live and silent auction is held in Minneapolis/St. Paul, netting over $90,000.
January 2010	Comprehensive census of five localities begins.
January 12, 2010	Earthquake of epic proportion hits Haiti.
January 26, 2010	First emergency medical relief team deployed to Haiti.
February 15, 2010	Second emergency medical relief team deployed to Haiti.
March 2010	New utility vehicle is purchased.
April 8, 2010	Third emergency medical relief team deployed to Haiti.
April 20, 2010	Census of five localities completed.
May 2010	Two of our three Klinik Timoun Nou Yo medical students graduate.
June 2010	Engineering student graduates.
Summer 2010	Expected date of KTNY completion (weather dependent).
May 2011	Expected graduation date for third medical student.

www.notimeforpoverty.org

MISSION STATEMENT & VALUES

MISSION STATEMENT

No Time For Poverty, in partnership with the community of Port Salut, Haiti, is working to eradicate the suffering and save the lives of desperately ill and starving children living in poverty. Using a comprehensive, community-based, health care program, we work to provide the highest possible standards of preventative, curative, and environmental health.

VISION

To see happy and healthy children living in Port Salut, Haiti.

VALUES

DETERMINATION

Solutions are by no means easy but they are not beyond the reach of our effort and resolve.

RESPECT

The belief systems of the culture in which we work are paramount and must be incorporated in to all aspects of what we do.

COURAGE

The poor are not only more likely to suffer, they are also less likely to have their suffering noticed. We will not let our children's suffering go unnoticed.

HUMILITY

We partner with others who have experience, knowledge, drive, and interest. There is always more to learn.

Continued...

Why Haiti?

The Republic of Haiti is a country that shares the Caribbean island of Hispaniola with the Dominican Republic. Haiti is located just 600 miles off the coast of Florida – only 90 minutes by air. Situated on the western one-third of Hispaniola, Haiti encompasses 10,714 square miles – slightly smaller than Maryland. Its population is estimated to be almost 10 million with 70 percent of Haitians living in rural areas. Haiti's terrain consists of rugged mountains with small coastal plains and river valleys. Once a lush tropical paradise, deforestation, hurricanes and flooding have lead to soil erosion resulting in only 28% of land being suitable for farming.

A former French colony, Haiti became the first independent black republic in the world as a result of a successful slave rebellion in 1804. Political and economic challenges and unrest continue to plague this tiny nation as it struggles toward democracy. Today, Haiti is the poorest country in the Western Hemisphere.

Why Haiti:

Because every child has an inherent right to life.

Because Haiti has the highest maternal, infant, and juvenile mortality rates in the Western Hemisphere

Because one out of every five children in Port Salut will die before they reach their fifth birthday

Because 50 percent of the population has no access to healthcare

Because it is inexcusable that a country in our hemisphere has only 1 hospital for every 100,000 children

Because it is inexcusable that a country in our hemisphere has 1.2 doctors and .04 dentists for every 10,000 children

Because HIV and Tuberculosis rates are by far the highest in the Western Hemisphere

Because the deaths of Haiti's children are from causes that are easily treatable.

Because no child need suffer when medications are available to treat and ease their pain.

Because the needless death of any child is intolerable especially when Haiti's children are easily within our reach to help.

Because Port Salut parents, like parents everywhere, dream that their children will have lives better than their own.

Because the government of Haiti is not currently in a position to provide primary healthcare to the hundreds of thousands of children in need.

Because the most effective way to provide primary healthcare to the children of the Port Salut region is through an outpatient pediatric clinic with a Comprehensive Community Outreach Program.

No Time For Poverty

Humble Service-Data Driven

Comprehensive Community Healthcare
for the
Children of Port Salut, Haiti
Serving 28,000 Children Each Year

CURATIVE

EDUCATIONAL

PREVENTATIVE

ENVIRONMENTAL

Klinik Timoun Nou Yo

Pre-Natal Care
Post-Natal Care
Nutrition
Breastfeeding

Size:	9,000 square foot pediatric healthcare facility	
Location:	Port Salut, Haiti	
Ages:	One day to 16-years-old	
Services:	Pediatric Care Emergency Services Same-Day Surgery X-Ray	Dental Care Pharmacy Laboratory
Features:	Six Exam Rooms Five Out-Patient Beds Nutritional Teaching Garden Hand-Washing Stations Nursing Station Covered Waiting Areas	Training & Conference Room Laundry Facility Indoor Atrium Garden of Life - Meditation Garden Children's Playground Office & Storage Space

Outreach Program

Location:	Remote villages surrounding Port Salut
Ages:	One day to five-years-old
Services:	Re-Hydration Treatment Pneumonia Detection Weight Monitoring Vaccinations Vitamin A Distribution Food Supplementation

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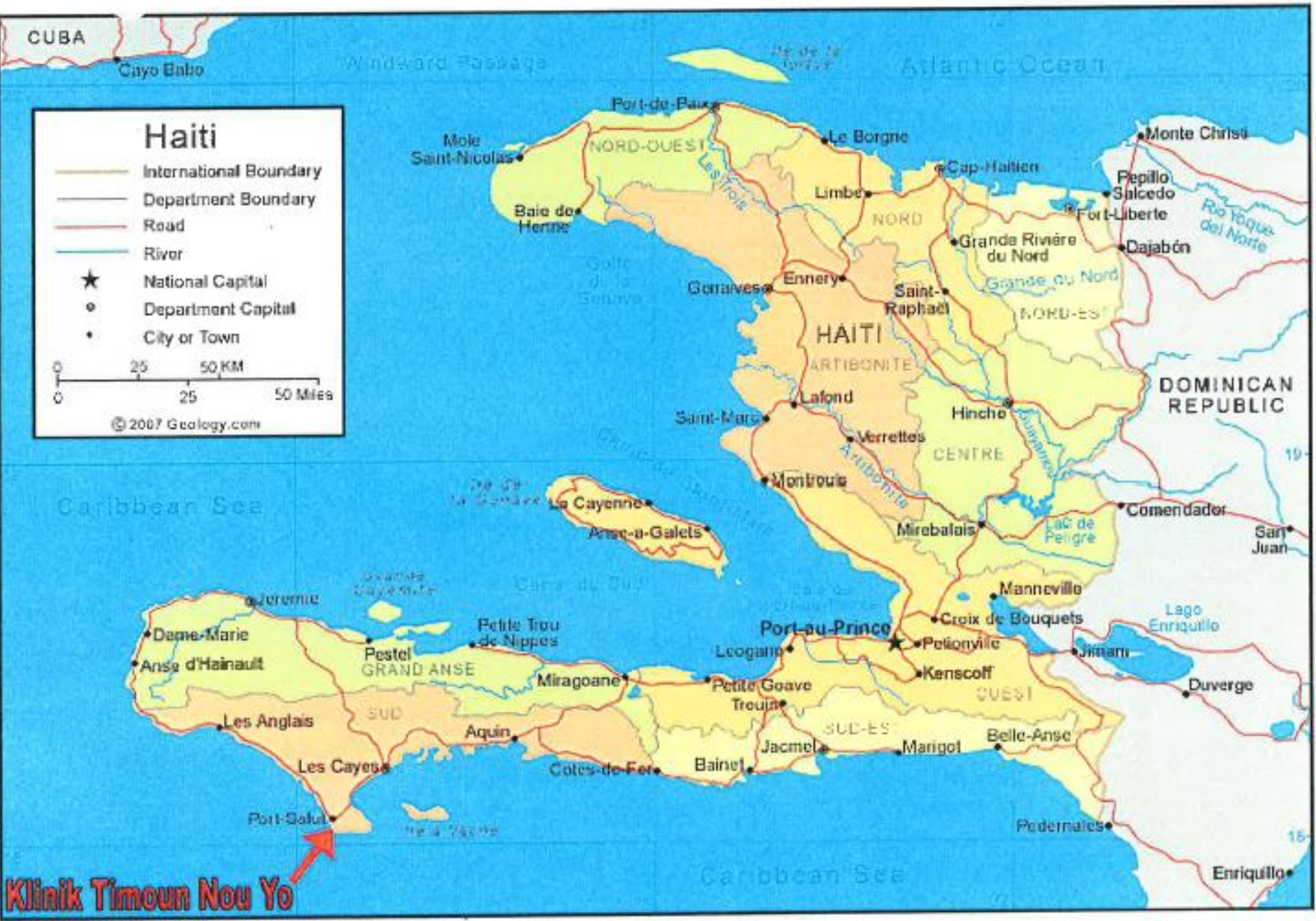

Haiti
International Boundary
Department Boundary
Road
River
National Capital
Department Capital
City or Town
0 25 50 KM
0 25 50 Miles
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CUBA
Cayo Babo
Windward Passage
Atlantic Ocean
Caribbean Sea
DOMINICAN REPUBLIC
HAITI
NORD-OUEST
NORD
NORD-EST
ARTIBONITE
CENTRE
OUEST
SUD-EST
SUD
GRAND ANSE
Port-de-Paix
Mole Saint-Nicolas
Baie de Henne
Le Borgne
Cap-Haitien
Limbe
Grande Rivière du Nord
Monte Christi
Pepillo Salcedo
Fort-Liberte
Dajabón
Gonaives
Ennery
Saint-Raphael
Lafond
Saint-Marc
Verrettes
Hinche
Montrouis
Mirebalais
La Cayenne
Anse-a-Galets
Comendador
San Juan
Mannevillo
Croix de Bouquets
Port-au-Prince
Petionville
Kenscoff
Jimani
Duverge
Jeremie
Dame-Marie
Anse d'Hainault
Pestel
Petite Trou de Nippes
Miragoane
Leogane
Petite Goave
Trouin
Les Anglais
Aquin
Les Cayes
Cotes-de-Fer
Bainet
Jacmel
Marigot
Belle-Anse
Port-Salut
Pedernales
Enriquillo
Klinik Timoun Nou Yo

Programs and Activities Description

The NTFP capstone team developed and implemented a template in collaboration with the NTFP organization to describe NTFP's programs in Port Salut including the "Klinik Timoun Nou Yo", which it translates to "Our Children's Clinic", scheduled to open November 19th, 2012. The NTFP capstone team deemed it essential to create and organize NTFP's program descriptions, as they will need documentation of their programs, partnerships, financial information and challenges to professionalize their activities. Having this description readily available at the opening of the clinic, will allow NTFP to become more independent from its founders and create the framework of their work. In addition the documentation of each program, created by the NTFP capstone team can be extracted for any request of funding, including grant or applied in their Fundraising Strategy. The other programs described in this section include the community Outreach Program, the breast-feeding program and the maternal health program.

Project Name: Klinik Timoun Nou Yo

Project Director: No Time For Poverty, 1865 Old Hudson Road, St. Paul, MN 55119

Contact Person: Michele Boston, Founder/Executive Director (TE: 651-714-6346)

Executive Summary:

Scheduled to open in fall of 2012, Klinik Timoun Nou Yo (Haitian Kreyol for "Our Children's Clinic) is a 9,000 square foot pediatric medical center in Port Salut, Haiti. In a region of over 56,000, Klinik Timoun Nou Yo (KTNY) is the only pediatric medical facility in the area and will provide care for over 31,000 children. While a small fee for service will be charged, no child will be turned away for a family's inability to pay. The clinic's curative care center will provide primary pediatric health care, pediatric dental care, same day surgery, and laboratory, radiology, and pharmacy services. In addition to the curative aspect of the program, KTNY will serve as the hub for a number of other programs including a nutrition center, an outreach program, ongoing education in the areas of prevention of disease, chronic illness, malnutrition, maternal health, etc., and a breastfeeding program which will provide community education and support via pre and post-natal classes and demonstrations. Expecting to treat approximately 18,000 children annually and provide dental care to at least 4,000 others, Klinik Timoun Nou Yo's Comprehensive Community Outreach Program will serve thousands more each year.

Programs and practices at Klinik Timoun Nou Yo will be data driven. To that end a comprehensive census of five localities in Port Salut was undertaken. The localities are the first five chosen by the community to participate in KTNY's Community Outreach Program. Not only does the survey assess the medical needs of the children in the region, it also evaluates vital health indicators including employment, sanitation, water, and other areas of concern. Ongoing data collection and research is considered absolutely critical to assessing the impact of medical intervention on the reduction in child mortality, malnutrition, and disease. Evaluation of the effectiveness of all programs will be measured by outcome-based assessments with the University of Minnesota assisting and supporting us in this process.

While KTNY will initially be directed by an American Pediatrician, we have begun and will continue to search for a qualified Haitian Medical Director. The clinic and its attendant programs will be staffed by Haitians in all positions. Imperative to the success of the clinic is the community's support. To that end, we have involved the community in every step of our process since we first began working in Haiti and will continue to do so.

Purpose Needs Statement

Problems/Issues:

The children of Haiti are dying at an alarming rate from illness and disease easily preventable and curable in the United States. It is an atrocity that these deaths are occurring in a county only 600 miles off the coast of Miami.

The following illnesses and diseases are but a few of the most common in Haiti and therefore are primarily what we expect to be prevalent in the children of Port Salut and most frequently treated at Klinik Timoun Nou Yo.

Diarrhea (Dyare): Infant and childhood diarrhea is the primary cause of death in Haiti. Episodes of diarrhea are more common among children who are malnourished and deficient in Vitamin A. According with the 2009 census 42.86% of the kids had suffered diarrhea in the last 2 weeks with villages like Maurace where the ratio was 72.73%

Pneumonia (Bwonch): According to some recent estimates, one might expect to find 150 cases of infant and child pneumonia for every 1,000 children in urban areas. The prevalence in rural areas like Port Salut is unknown. Pneumonia is the second cause of death in children after diarrhea. Bacterial in origin, pneumonia would respond to antibiotic treatment if cases were detected and referred early for treatment.

Hepatitis (Fiev Jonn/Hepatit): Both Hepatitis A and B are endemic in Haiti.

Tetanus (Ko red): Neonatal tetanus is one of the principle causes of death in newborns.

Vitamin A Deficiency: The prevalence of children who suffer from blindness (Conjunctival Xerosis) due to deficiency of Vitamin A is high.

Maleria (Fiev Malaria): Endemic in Haiti, approximately 80% of the rural population is at risk of contracting this disease.

Cholera: Not seen before in Haiti, cholera is now a killer in most regions in Haiti.

Objective of Klinik Timoun Nou Yo:

To save lives of suffering and dying children in the region of Port Salut by reducing infant, child, and adolescent suffering and with the implementation of a high quality comprehensive community based health system where no child is turned away for an inability to pay.

Expected Outcomes:

KTNY will have an arsenal of equipment, supplies, and pharmaceuticals to help a well-trained Haitian staff provide the finest pediatric medical and dental care to children in this region where the burdens of poverty and disease are some of Haiti's works. It is expected that KTNY will provide medical care and treatment to approximately 18,000 children per

year within the clinic walls. It is also estimated the KTNY will provide dental care and treatment to approximately 4,000 children annually.

Klinik Timoun Nou Yo will provide service in the following areas:

Primary Pediatric Medical Care. Half of the community in Port Salut are children under the age of sixteen. Yet these children have little or no access to a physician, nurse or dentist. Providing care to children in their formative years is generally critical to preventing health problems in later years. In Haiti, however, early childhood medical intervention means the difference between life and death. Without KTNY, children will continue to die at alarming rates.

Pediatric Dental Care. The only dental service available in the region of Port Salut is at the local government hospital. As is the case with the medical care it offers, dental treatment is substandard and unaffordable to most. The lack of a nutritious diet causes early teeth rotting and bone disease in children. Preventative dental treatment for the children of Port Salut will critically reduce the pain, suffering and disease these children are currently experiencing.

Emergency Services. Currently, there is no emergency room specifically serving children in the region of Port Salut. KTNY will offer a quick response team thereby maximizing the likelihood that a child will survive accidents and other emergencies.

Laboratory. The only standing laboratory in the Port Salut region is located in the government hospital. Prior to the 2010 earthquake, the laboratory was poorly equipped and unaffordable to most. Our children's clinic will offer a wide array of testing and be available to all children regardless of an ability to pay.

X-ray. There is only one other standing x-ray machine in the Port Salut region. Diagnosis and treatment is often predicated on a physician's "gut instinct" or "best guess." Even prior to the earthquake of January 12th, it was not uncommon to find limb deformities resulting either from a lack of medical treatment or the rearranging of broken bones without guidance from x-ray. Since the quake, the need for equipment in Port Salut is direr than before. KTNY will have both stationary and portable x-ray equipment and a program for maintenance and repair so as to maximize their usage and effectiveness.

Pharmacy. While there are some pharmacies in the Port Salut region, shelves are frequently bare. Moreover, the cost of medications is often prohibitive to the desperately poor who comprise the community. Not only will KTNY contain a well-stocked pharmacy with temperature control capabilities but will offer a separate medication administration room and counseling program whereby every child's caretaker will receive guidance and practice in the means, method and timing of administration of their child's medication(s).

Same-Day Surgery. The region's government hospital does contain an operating room only recently equipped. However contaminated conditions render a questionable environment in which to perform surgery. Our children's clinic will be fully equipped and sterile. No child in need of a surgical procedure will be turned away for a family's inability to pay. Visiting

medical teams will utilize proper surgical equipment and adequate supplies to perform critically needed same day surgical procedures that in the U.S. are hardly life threatening but in Haiti are life saving.

Community Education. A number of educational programs are deemed critical to providing quality medical care and improving the health of children and families being served. Some of these include post-natal care, nutrition, rehydration therapy, breastfeeding, etc.

Data Collection. Programs and practices at KTNY will be data driven. In 2010, a comprehensive census of five localities in Port Salut was undertaken. The localities are the first five chosen by the community to participate in NTFP's comprehensive medical Outreach Program. Not only does the survey assess the current medical needs of the children in the region, it also evaluates vital health indicators including employment, sanitation, water and other areas of concern. Ongoing data collection and research is considered absolutely critical to assessing the impact of medical intervention on the reduction in child mortality, malnutrition and disease.

Clearinghouse. The only medical services available in the Port Salut region other than those provided by its local government hospital are those provided by visiting agencies and organizations via mobile clinics. Currently, there exists no coordination among groups, resulting in duplication of efforts in some areas and deficiencies of service in others. KTNY will identify, locate and partner with willing visiting medical groups and organizations to assure a meaningful distribution of services to maximize benefit to the children in the community. NTFP will also make available to visiting teams its data, research, best practices and protocols.

Why does this matter:

There are no other medical alternatives for the children in Port Salut, Haiti. As it explained by the directors of NTFP, "There is shame, we believe, in the death of every child in Haiti as Haiti's children die of conditions so easily treated in the U.S. Dehydration, the number one cause of death among Haitian children, is treatable with a mixture of sugar, salt and water. The second leading cause of death of Haiti's children is pneumonia, treatable with antibiotics. We could not fathom the death of children from causes so readily treated in the United States. The fact that children were dying in America's "backyard" made it more unconscionable and egregious, and we were angry for it." As others factors that creates a sense of urgency for the existence of KTNY, though the vast majority of women breastfeed, very few in any of the localities practice breastfeeding alone for the recommended six months following delivery by the World Health Organization (WHO), only 11.5% of children in all five localities have a vaccination status that can be considered "up to date" and timely based on the WHO recommended vaccine schedule for Haiti. One quarter (26.7%) of the children in the selected localities are below the normal limits of weight for age, indicating some degree of growth retardation and malnutrition. Clearly, No Time for Poverty can play a significant role in improving and protecting the health of the children in these five localities.

Approach

Klinik Timoun Nou Yo will provide preventative and curative care to children in the region of Port Salut, Haiti.

Services at the clinic will include the following:

- Well baby clinic (see exams detail in Annex 1) Diagnosis and treatment of: Diarrhea, Dehydration, Pneumonia, Malaria, Typhus, HIV/Aids, Cholera, Worms and Intestinal Parasites, Tuberculosis, Meningitis, Hepatitis, Gangrene, Tetanus, Colds/Flu, Respiratory issues, Anemia, Hernia, etc.
- Treatment of injuries including: Burns, cuts, punctures, fractures, rashes, skin problems, etc.
- Vaccinations/Vitamins
- On-site Laboratory
- On-site Radiology
- On-site Pharmacy

The clinic will also host a number of educational programs including pre-natal care, post-natal care, maternal heath, and breastfeeding. A nutrition center will also be housed at the clinic. This center will work with severely malnourished children chosen to participate in a food program.

Imperative to the success of KTNY is having a well-trained and knowledgeable staff. Job Descriptions for each position are written and each staff will be fully trained in all aspects of their position and in KTNY policies and procedures (we have to include these descriptions in the folder that we are creating with these descriptions as part of the annex's - pending). An American Interim Medical Director has been hired and will work hands on with medical staff assisting in training to ensure that all staff are trained in the highest standards of infection control, health care and service.

Evaluation/Measures of Success

A paramount consideration deemed critical in reducing the infant, child, and adolescent mortality in the region of Port Salut is that program development and implementation be research based and data driven. In the Annex 2 you can find details of the public health survey that was completed in the region of Port Salut, Haiti, in the summer of 2010 that serves as the basis for all the programs implemented by KTNY.

By "data driven" we refer to two primary things: monitoring and evaluation. Monitoring refers to the annual assessment of our program and as such will be built into daily program management via basic record keeping systems. In addition to collecting, maintaining, and collating information to monitor KTNY, certain features of it will be evaluated over time by person outside of daily functioning of the clinic. To this end, we have entered into a

Memorandum of Understanding with the Regents of the University of Minnesota by and through its Academic Health Center for collaboration in providing educational and research experiences for students, residents, and faculty. This partnership between No Time For Poverty and the University of Minnesota will assist KTNY in promoting its mission that development and treatment be data-driven and quality of care be maximized.

Obviously, the true measure of success of Klinik Timoun Nou Yo will be determined by the Key Performance Indicators selected by NTFP to evaluate the success of the programs detailed in this document.

Project Name: Community Outreach Health Care Program

Project Director: No Time For Poverty, 1865 Old Hudson Road, St. Paul, MN 55119

Contact Person: Michele Boston, Founder/Executive Director (651-714-6346)

Executive Summary:

Expecting to treat approximately 18,000 children annually and provide dental care to at least 4,000 others, Klinik Timoun Nou Yo's Comprehensive Community Outreach Program will serve thousands more each year.

Programs and practices at Klinik Timoun Nou Yo will be data driven. To that end a comprehensive census of five localities in Port Salut was undertaken. The localities are the first five chosen by the community to participate in KTNY's Community Outreach Program. Not only does the survey assess the medical needs of the children in the region, it also evaluates vital health indicators including employment, sanitation, water, and other areas of concern. Ongoing data collection and research is considered absolutely critical to assessing the impact of medical intervention on the reduction in child mortality, malnutrition, and disease. Evaluation of the effectiveness of all programs will be measured by outcome-based assessments with the University of Minnesota assisting and supporting us in this process.

While KTNY will initially be directed by an American Pediatrician, we have begun and will continue to search for a qualified Haitian Medical Director. The clinic and its attendant programs will be staffed by Haitians in all positions. Imperative to the success of the clinic is the community's support. To that end, we have involved the community in every step of our process since we first began working in Haiti and will continue to do so.

Purpose Needs Statement

Problems/Issues:

Access to care in this region is significantly limited, and mostly by cost. In accordance with the 2009 census nearly three fourths of respondents reported that they or a family member were unable to obtain care that was important, and over 90% of these indicated that the reason was that care was too expensive. In addition, people overall perceive their health to be very poor. This information strongly supports the need for provision of further affordable clinical services for inhabitants of these five localities.

While KTNY will serve a huge number of children at the clinic, there are still thousands of children who live in remote areas and do not have easy access to the clinic. To meet the needs of these children a Community Outreach Health Care Program is imperative for children ages 0-5. Five communities have been chosen by members of the Peasant Movement of Port Salut to participate in this program.

Objective of KTNY – Community Outreach Program:

To establish community outreach programs that will target on prevention of illness and disease in children ages 0 – 5 and will actively involve the communities in the area. Community's participation in planning, development and implementation of its outreach program will increase their sense of ownership in it and, therefore, less dependency upon traditional models of health delivery, as well as a more sustainable approach to improving the health of the community's children and reducing mortality rates.

Expected Outcomes:

Children who otherwise would not be able to get to a medical clinic will now have access to a Community Health Agent. The health agent will be able to detect, monitor, and treat a number of issues, which if left untreated could result in death. The benefits of the Health Agent model whereby local persons serve as Health Agents include:

- The services offered by the Health Agent will more likely be utilized if the agent is chosen by the community.
- The Health Agent understands the culture, language, and practices of the community because he/she lives in it.
- The Health Agent lives within the remote community and is therefore available to serve.
- The time and money required to train a Health Agent is substantially less than that of other medical personnel, yet the Health Agent can administer protocols that will improve the health of children ages 0-5 years and drastically reduce infant and child mortality in the localities.

Why does this matter:

There are many reasons why this matters, the 2009 survey provides a picture of the health status of the children in each of the five localities. Overall, the point prevalence of illness in children is striking. Survey results indicate that, at any given time, 42.9% of the children have diarrhea, 55.6% have a cough indicative of an upper respiratory tract infection, and 52.6% have a fever. Children in Choquette and Maurace have even higher percentages of these illnesses, which should elicit more specific attention. As death due to dehydration secondary to diarrhea and pneumonia secondary to acute upper respiratory tract infections make up the majority of under-five mortality in Haiti, these results are sobering.

A community health agent is a person who responds to the health needs of the community in which he or she resides. We believe that with proper training, management, and supervision, the Health Agent can be an effective front line worker of first contact. Clinics/Hospitals address curative health needs. Community Outreach Programs target prevention. We believe that in Haiti where one out of eight children die before their fifth

birthday, a well managed, data based combination of the two models, along with an educational program, will have the greatest impact in improving the health of children ages 0 – 16 and reducing infant and child mortality.

Approach

The primary functions of the Health Agent include:

- Administering oral rehydration solutions (ORS) for the treatment of dehydration.
- Demonstrating the making of ORS and teaching members of the community when and how to use it.
- Promoting immunization of all children via rally posts within and around the community.
- Distributing Vitamin A to prevent blindness.
- Distributing anti-helminthics for deworming.
- Monitoring children's weight.
- Detecting pneumonia and other respiratory infection.
- Treating simple illnesses and applying first aid.
- Referring persons with illness untreatable by the Health Agent to Klinik Timoun Nou Yo.
- Assisting in setting up mothers groups and fathers groups.
- Maintaining data useful for continued program planning and development.
- Surveying the community as may be necessary.

One Health Agent will be selected by each community in a prescribed manner with KTNY direction. The method is as follows:

1. An "advertisement" and description of the health agent position via letter and work of mouth will be spread throughout the community with the location, meeting date and time, and a request for nominations. Individuals may nominate themselves.
2. The community meeting will begin with a review of the health agent position, job description, and qualifications including:

    - Age 18 or older
    - Ability to read and write
    - Residence within the community
    - Commitment to remain in the community. Should an agent move out of the community, the community may be exempted from having the outreach program in their community
    - Full-time availability
    - Proactive and independent to decide better ways to work with the community
    - Be compassionate and sensitive
    - Be well respected in the community
    - Capable of read/write
    - Good Analytical skills

- Eager to learn
- Hard working
- In good health
- May be male or female

3. Nominations will be presented to the community. It will eliminate those individuals deemed “unworthy” of the position.
4. Remaining candidates will respond to a set of interview questions
5. A preselected committee chosen by the community will convene to another location for voting. The majority candidate will be chosen. KTNY will have no voting rights.
6. The committee will reconvene with the community and announce its decision.

When a Health Agent from each community has been selected, they will complete an intensive training program, which will cover the following areas:

a) Care of Children Under Five Years Old

    i) How to recognize a sick child
    ii) How to care for a sick child.
    iii) How to weigh children and use growth charts: how to measure the mid-upper arm circumference (MUAC).
    iv) Malnutrition: types, causes and prevention.
    v) Malnutrition: supplementary and therapeutic feeding.
    vi) Hygiene.
    vii) Immunizations.
    viii) Diarrhea and the use of oral rehydration salts (ORS).
    ix) Acute respiratory infection (ARI) and its treatment.
    x) AIDS: its recognition and management.
    xi) Mother to child transmission.

b) Prevention and Treatment of Common Illnesses

    i) Diarrhea and worms.
    ii) Abdominal pain.
    iii) Chest infections.
    iv) Tuberculosis
    v) Malaria.
    vi) Typhoid and cholera.
    vii) Measles.
    viii) Leprosy
    ix) Eye diseases.
    x) Ear diseases
    xi) Mouth and tooth problems.
    xii) Cholera

c) First Aid

   i) Cuts and bruises: bandaging
   ii) Burns
   iii) Bone injuries
   iv) Animal bites and injuries
   v) Cardiopulmonary resuscitation

d) Parts of the Body and How They Work (Anatomy and Physiology)

e) General

   i) The role and function of the CHA
   ii) How a clinic/hospital works
   iii) How and when to refer patients
   iv) Record keeping and simple accounting
   v) Keeping and using a medical kit
   vi) Methods of teaching and communicating
   vii) Leading discussion groups: raising awareness
   viii) Details of the health project
   ix) National health problems and programs
   x) Cooperating with others

The community Health Agents will be required to pass oral and/or written practical tests of all training areas. Upon successfully completing all training areas, the Community Health Agent will be graduated at a formal ceremony within their community. At that time they will be presented with their graduation certificate along with their first health care kit.

Initially, Health Care Agents will be encouraged and supervised by a nurse who will visit for the first year each community one time per week. While some community health agent models use volunteers who are not compensated for their work, we believe that paid agents are likely to be far more dedicated and effective. Moreover, families of Health Agents will need to depend upon them as wage earners. It is unreasonable, therefore, to expect that Agents receive nothing for their work. Therefore, Health Agents working with NTFP will be paid in accordance with the rate of salaried health agents in Haiti and national labor laws.

Evaluation/Measures of Success

Initial measures of success will be based on percentage of children seen and treated by community health agents.

Our goals for the first year of the program are as follows:

- Vaccinate at least 70% of children under age five

- Vaccinate at least 60% of women of child bearing age (15-49) with tetanus vaccine
- Provide at least one visit of prenatal care to 50% of pregnant women
- Document the successful mixing of oral rehydration solution for diarrhea by at least 60% of women/mothers.
- Weigh at least 60% of children under five years at least three times per year.

Project Name: Breast Feeding Program

Project Director: No Time For Poverty, 1865 Old Hudson Road, St. Paul, MN 55119

Contact Person: Michele Boston, Founder/Executive Director (651-714-6346)

Executive Summary:

The clinic's curative care center will provide primary pediatric health care, pediatric dental care, same day surgery, and laboratory, radiology, and pharmacy services. In addition to the curative aspect of the program, KTNY will serve as the hub for a number of other programs including a nutrition center, ongoing education in the areas of prevention of disease, chronic illness, malnutrition, etc., a Community Outreach Health Care Program, a Maternal Health Program, and a Breast Feeding Program which will emphasize the importance of breastfeeding children for at least the first year of life.

Programs and practices at Klinik Timoun Nou Yo will be data driven. To that end a comprehensive census of five localities in Port Salut was undertaken. The localities are the first five chosen by the community to participate in KTNY's Community Outreach Program. Not only does the survey assess the medical needs of the children in the region, it also evaluates vital health indicators including employment, sanitation, water, and other areas of concern. Ongoing data collection and research is considered absolutely critical to assessing the impact of medical intervention on the reduction in child mortality, malnutrition, and disease. Evaluation of the effectiveness of all programs will be measured by outcome-based assessments with the University of Minnesota assisting and supporting us in this process.

Purpose Needs Statement

Problems/Issues:

Breastfeeding not only promotes longer team health but also is key to reducing child mortality. While the benefits of breast milk are well known, many women in Haiti do not breast feed. In the census of 2009 it was seen that though the vast majority of women breastfeed, very few in any of the localities practice breastfeeding alone for the recommended six months following delivery. There are a number of myths and cultural beliefs that have lead to this. Some of these myths include the belief that colostrum is poisonous, that a mother's milk is easily spoiled and turned poisonous by any personal trauma and the baby must be immediately weaned, and that breastfeeding can cause mental illness.

Objective of KTNY – Breast Feeding Program:

To increase the number of women who breast feed their babies for at least one year in the region of Port Salut, Haiti. According with the census, the average length of using

breastfeeding exclusively, as the only source of nutrition, among the mothers with children under the age of 5 ranges from 1.3 months in Roche Jabouin to 5.1 months in Choquette. Of note, none of the communities exhibit the WHO recommended length of time for exclusive breastfeeding of 6 months.

Expected Outcomes:

Babies who receive adequate amounts of breast milk will have stronger immune systems thus reducing the number of sick babies. The World Health Organization in its "10 facts about breastfeeding" highlights the following benefits:

- It gives infants all the nutrients they need for healthy development.
- It is safe and contains antibodies that help protect infants from common childhood illnesses - such as diarrhea and pneumonia, the two primary causes of child mortality worldwide.
- Breast milk is readily available and affordable, which helps to ensure that infants get adequate sustenance.
- Breastfeeding also benefits mothers. The practice when done exclusively is associated with a natural (though not fail-safe) method of birth control (98% of protection in the first 6 months after birth).
- It reduces risks of breast and ovarian cancer later in life, helps women return to their pre-pregnancy weight faster, and lowers rates of obesity.
- Beyond the immediate benefits for children, breastfeeding contributes to a lifetime of good health. Adults who were breastfed as babies often have lower blood pressure and lower cholesterol, as well as lower rates of overweight, obesity and type-2 diabetes.
- There is evidence that people who were breastfed perform better in intelligence tests.
- Giving a baby under 6 months of age any liquids or foods other than breast milk increases the risk of diarrhea and other illnesses. Water and other liquids or foods may be contaminated, which can cause diarrhea.

Why does this matter:

Haiti's future lies in its children. The UNICEF and WHO in their work "Facts for Life" state "Babies who are breastfed are generally healthier and achieve optimal growth and development compared to those who are fed formula milk. If the vast majority of babies were exclusively fed breast milk in their first six months of life – meaning only breast milk and no other liquids or solids, not even water – it is estimated that the lives of at least 1.2 million children would be saved every year around the world. If children continue to be breastfed up to two years and beyond, the health and development of millions of children would be greatly improved. Infants who are not breastfed are at an increased risk of illness that can compromise their growth and raise the risk of death or disability. Breastfed babies

receive protection from illnesses through the mother's milk. Breastfeeding is the natural and recommended way of feeding all infants, even when artificial feeding is affordable, clean water is available, and good hygienic conditions for preparing and feeding infant formula exist."

Approach

This program will identify children under six months of age who are not being breastfed and provide targeted support, education, and counseling for their mothers. The program will provide community education and support via pre and post-natal classes, mothers groups, and demonstrations. The program will also address breastfeeding of HIV identified children for up to one year of age.

Both in the clinic and via the Community Outreach Program, mothers will be educated in the benefits of breastfeeding. Mothers will be taught how long it takes for milk production to begin, what practices increases milk supply, and how to teach the infant to latch correctly. Mothers will also be educated in the benefits of colostrum and the importance of its immunological effects as well as its laxative effect.

Evaluation/Measures of Success

Measures of success will evaluated by increased numbers of mothers' breastfeeding their children for at least one year.

Project Name: Maternal Health Program

Project Director: No Time For Poverty, 1865 Old Hudson Road, St. Paul, MN 55119

Contact Person: Michele Boston, Founder/Executive Director (651-714-6346)

Executive Summary:

The clinic's curative care center will provide primary pediatric health care, pediatric dental care, same day surgery, and laboratory, radiology, and pharmacy services. In addition to the curative aspect of the program, KTNY will serve as the hub for a number of other programs including a nutrition center, ongoing education in the areas of prevention of disease, chronic illness, malnutrition, etc., a breastfeeding program which will provide community education and support via pre and post-natal classes and demonstrations, a Community Outreach Health Care Program and a Maternal Health Program.

Programs and practices at Klinik Timoun Nou Yo will be data driven. To that end a comprehensive census of five localities in Port Salut was undertaken. The localities are the first five chosen by the community to participate in KTNY's Community Outreach Program. Not only does the survey assess the medical needs of the children in the region, it also evaluates vital health indicators including employment, sanitation, water, and other areas of concern. Ongoing data collection and research is considered absolutely critical to assessing the impact of medical intervention on the reduction in child mortality, malnutrition, and disease. Evaluation of the effectiveness of all programs will be measured by outcome-based assessments with the University of Minnesota assisting and supporting us in this process.

While KTNY will initially be directed by an American Pediatrician, we have begun and will continue to search for a qualified Haitian Medical Director. The clinic and its attendant programs will be staffed by Haitians in all positions. Imperative to the success of the clinic is the community's support. To that end, we have involved the community in every step of our process since we first began working in Haiti and will continue to do so.

Purpose Needs Statement

Problems/Issues:

While the focus of our program of comprehensive medical care in Port Salut, Haiti is on children, we recognize the enormous need to improve the maternal health in the region. Far too many deaths of mothers are due to hemorrhaging during or shortly after birth. Other causes related to pregnancy include infection or sepsis from non-sterile circumstances, or eclampsia from high blood pressure. Mothers also die of diseases exacerbated during pregnancy, including malaria, HIV/Aids, and anemia.

Objective of KTNY – Maternal Health Program:

To prevent pregnancy related deaths in the region of Port Salut, Haiti No Time For Poverty will implement this program with two objectives; First, to collaborate and partner with Hopital Communautaire in assisting them to bring to fruition their new OB/GYN program. Second, working in conjunction with this program, No Time For Poverty will develop a program aimed at reducing maternal mortality rates in Port Salut.

Expected Outcomes:

Countless mothers, who otherwise might die from causes related to pregnancy, will live. No Time For Poverty recognizes that a truly comprehensive pediatric health program must address maternal health, the components of which would include at least the following:

- Antenatal care (care during pregnancy). Regular checks during pregnancy.
- Attendance at birth by well-trained traditional birth healer.
- Postnatal care. Regular well baby checks following birth.
- Referral to Klinik Timoun Nou Yo and Communautaire for services to baby and mother required.

Why does this matter?

•Most women in the Port Salut area, according with the census, seek prenatal care (approximately 80%), though they appear to do so only later in their pregnancy. The provision of prenatal care therefore represents an important way for a new clinic to provide a needed service to the population. Also, education and incentives that encourage women to receive prenatal care as early as their first trimester of pregnancy would improve maternal and infant health outcomes.

• According to the census, the majority of women (approximately 80%) give birth with the help of auxiliary midwives. These midwives represent important potential collaborators for a public health outreach program, both to provide training to improve their capability and to partner with for the sake of educating and reaching pregnant women within the communities.

* According with the WHO (November 2010) every day, approximately 1000 women die from preventable causes related to pregnancy and childbirth and 99% of all maternal deaths occur in developing countries. In addition, maternal mortality is higher in rural areas and among poorer and less educated communities, but skilled care before, during and after childbirth can save the lives of women and newborn babies.

Approach

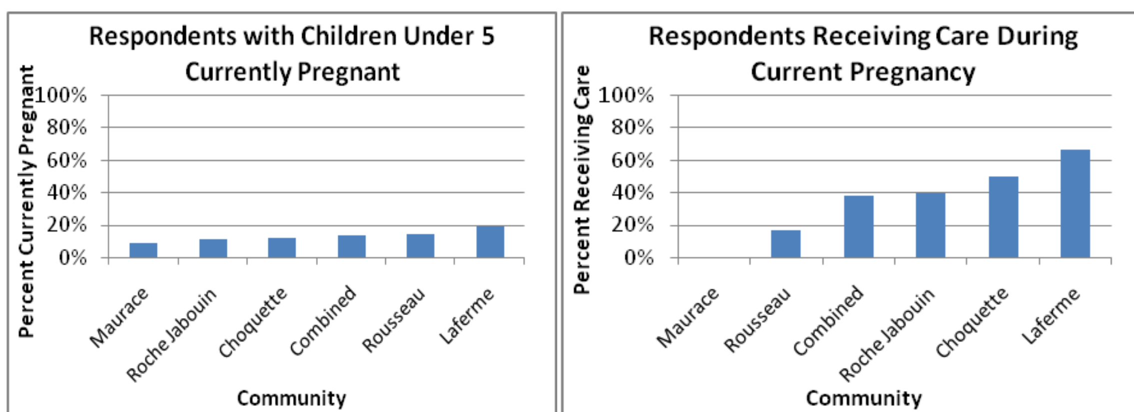
Appropriate health care for mothers has not been available in Port Salut. Programs have been non-existent, too distant, or too expensive. No Time For Poverty recognizes that a truly comprehensive pediatric health program must address maternal health, the components of which would include at least the following:

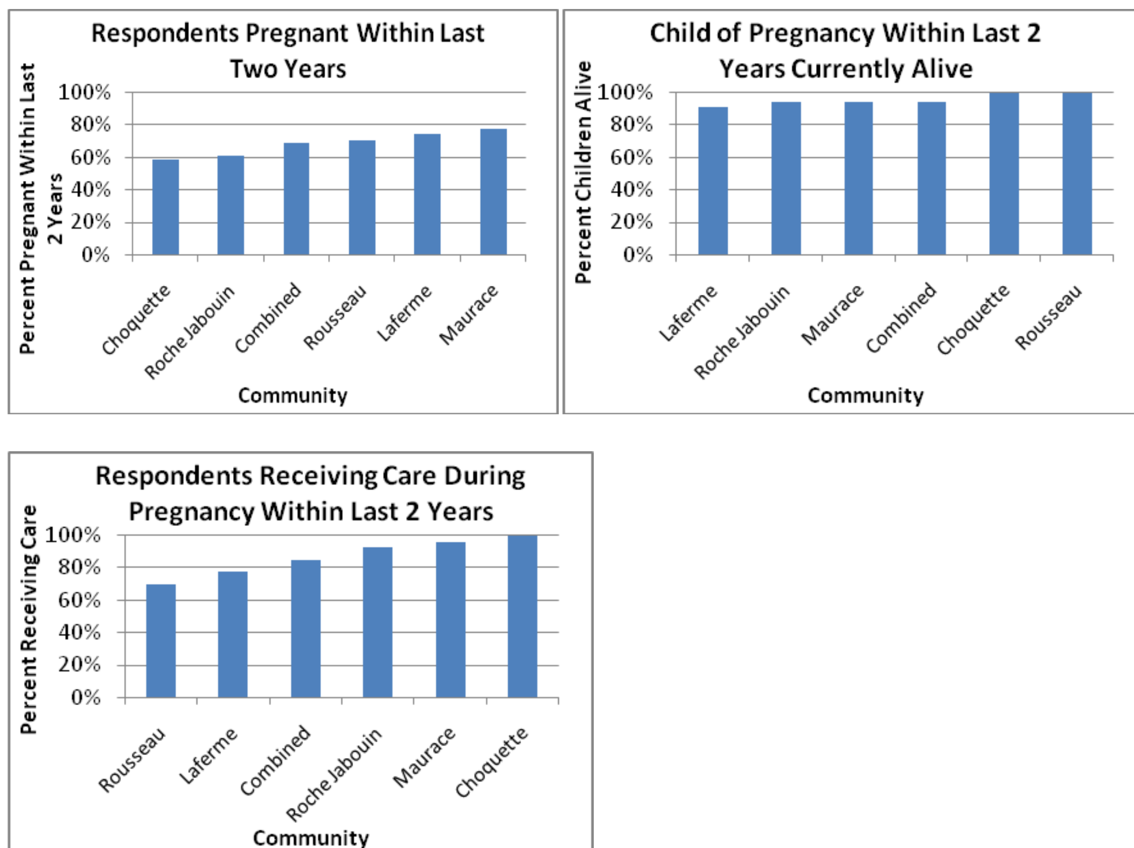
- Antenatal care (care during pregnancy). Regular checks during pregnancy via Community Outreach Program.
- Attendance at birth by well-trained traditional birth healer.
- Education seminars for pregnant mothers.
- Postnatal care. Regular well baby checks following birth.
- Immunization program for women of childbearing age.

Evaluation/Measures of Success

Evaluation of this program will be measured by numbers attending educational seminars, number of births attended by well-trained birth healers, numbers of mother/child well baby visits, and percentage of prenatal visits by Community Health Agents.

Overall, 33% of the respondents to the census (N=133) were mothers with children less than 5 years of age in the household. Of these, 13% (N=18) reported that they are currently pregnant (this does not include women who are currently pregnant but do not have a child under 5 years of age in the household). 38% of the currently pregnant women reported that they have received care during their pregnancy (N=8). Throughout all five communities, the average number of times women who were pregnant within the last two years received care for those pregnancies is 3.3 times.





The women that gave birth to a child within the last two years were asked questions about who assisted with the child's delivery. **Throughout all five communities, the majority of the women received assistance from an auxiliary midwife (80%).**

	Nurse Midwife	**Auxiliary Midwife**	**Doctor**	**Family Member**	**Traditional Birth Attendant**
Choquette	41.2	58.8	0	0	0
Rousseau	2.9	82.3	5.9	8.8	0
Maurace	0	95.5	4.6	0	0
LaFerme	9.7	80.7	6.5	6.5	0
Roche Jabouin	17.2	75.9	13.8	6.9	13.8
Total	**12.0**	**79.7**	**6.8**	**5.3**	**3**

The maternal mortality ratio in developing countries is 290 per 100 000 births versus 14 per 100 000 in developed countries (World Health Organization, 2012). There are large disparities between countries, with some countries having extremely high maternal mortality ratios of 1000 or more per 100 000 live births. There are also large disparities within countries, between people with high and low income and between people living in rural and urban areas.

Women die as a result of complications during and following pregnancy and childbirth. Most of these complications develop during pregnancy. Other complications may exist

before pregnancy but are worsened during pregnancy. The major complications that account for 80% of all maternal deaths are:

- severe bleeding (mostly bleeding after childbirth)
- infections (usually after childbirth)
- high blood pressure during pregnancy (pre-eclampsia and eclampsia)
- obstructed labour
- unsafe abortion.
- The remainder are caused by diseases such as malaria, anaemia and HIV/AIDS during pregnancy.

Maternal health and newborn health are closely linked. More than three million newborn babies die every year, and an additional three million babies are stillborn.

Most maternal deaths are avoidable, as the health-care solutions to prevent or manage complications are well known. All women need access to antenatal care in pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth. It is particularly important that all births are attended by skilled health professionals, as timely management and treatment can make the difference between life and death.

- **Severe bleeding** after birth can kill a healthy woman within two hours if she is unattended. Injecting oxytocin immediately after childbirth effectively reduces the risk of bleeding.
- **Infection** after childbirth can be eliminated if good hygiene is practiced and if early signs of infection are recognized and treated in a timely manner.
- **Pre-eclampsia** should be detected and appropriately managed before the onset of convulsions (eclampsia) and other life-threatening complications. Administering drugs such as magnesium sulfate for pre-eclampsia can lower a woman's risk of developing eclampsia.
- **Obstructed labour** occurs when the baby's head is too big for the mother's pelvis or if the baby is abnormally positioned for birth. A simple tool for identifying these problems early in labour is the partograph – a graph of the progress of labour and the maternal and fetal condition. Skilled practitioners can use the partograph to identify and manage a slow labour before the lives of the mother and baby are threatened. If necessary, a caesarean section can be performed.

To avoid maternal deaths, it is also vital to prevent unwanted and too-early pregnancies. All women, including adolescents, need access to family planning, safe abortion services to the full extent of the law, and quality post-abortion care. Improving maternal health is one of the eight Millennium Development Goals (MDGs) adopted by the international community in 2000. Under MDG5, countries committed to reducing maternal mortality by three quarters between 1990 and 2015. Since 1990, maternal deaths worldwide have dropped by 34%.

Partnerships

No Time For Poverty maintains partnership relations with different agencies in order to achieve its objectives. The selected agencies are established non-profits organizations that are actually acting in Haiti and at the same time well recognized for their positive impact in the recovery of the country. No Time For Poverty and these organizations have chosen to work together to increase the likelihood of each achieving their mission and to amplify their reach.

The list of partners and the nature of their partnership is described below:

AGENCY	DESCRIPTION	PARTNERSHIP
Partners In Health	Under the direction of Dr. Paul Farmer, PIH is a world-renowned Health Agency in Haiti and other developing countries.	Director of Strategic Planning and Operations, Loune Viaud, has been an integral part in obtaining our “License to Open” and assisting with other government regulations and requirements.
Haitian Health Foundation	The mission of the Haitian Health Foundation is to improve the health and well being of the poor, sick, and the infirm of the greater Jérémie area, with a focus on women and children.	Director, Dr. Bette Gebrian, has been instrumental in mentoring and assisting us in the development of the clinic, our census, and our community outreach program.
Institut Brenda Strafford	Institut Brenda Strafford is the recognized leader in Ophthalmology and ENT in Haiti.	Directors, Richard and Chantal Laviolak, have served as advisors in the areas of Haitian employment law and other employment related information.
St. Damien Hospital	Located in Port au Prince, St. Damien’s provides high quality medical treatment for disadvantaged and sick children in Haiti.	Members of the St. Damien’s staff have been extremely helpful in answering questions and assisting us as needed.
Hospital Sisters Mission Outreach	Hospital Sisters Mission Outreach responds to the sick, poor and needy through a medical equipment and supply recovery and distribution program and education and awareness opportunities.	Hospital Sisters Mission Outreach has been instrumental in helping us acquire and ship necessary equipment and supplies to the clinic in Haiti.
Catholic Relief Services	In Haiti, CRS responds to emergencies, provides agriculture assistance, supports education, and works to enhance the health care system throughout the country.	We are working with Catholic Relief Services in Les Cayes, Haiti, in a variety of ways, including Health Agent training, food supplementation, and resource and information sharing.
University of Minnesota	One of the nation’s largest schools, the University of Minnesota offers baccalaureate, master’s, and doctoral degrees in virtually every field—from medicine to business, law to liberal arts, and science and	On May 19, 2011, NTFP entered into a Memorandum of Understanding with the Regents of the U of MN by and through its Academic Health Center for collaboration in providing educational and research

	engineering to architecture.	experiences for students, residents, and faculty. This partnership between the U of MN and NTFP will assist NTFP in promoting its mission that development and treatment be data-driven and quality of care be maximized. In addition, this partnership paves the way for collaboration between Haitian and American medical personnel.
Caris Foundation	The Caris Foundation in Haiti is working in conjunction with the National HIV Pediatric Program to help young children born to HIV positive mothers. They support and train hospitals in PCR testing of infants as young as four weeks old. When babies are identified as being HIV positive, we help in providing enough food and the right medicines, as well as encouraging routine checkups.	Klinik Timoun Nou Yo will be a testing sight for the Caris Foundation and will work in conjunction with the local government hospital to ensure that identified children will receive the food and medicine that Caris provides. We will also conduct routine checkups of these children.
Vitamin Angels	Vitamin Angels reduces child mortality worldwide by connecting essential nutrients with infants and children under five.	NTFP has worked with Vitamin Angels since 2009. Through this collaboration NTFP has received and dispersed thousands of multi-vitamins and Vitamin A to the children of Haiti.
COFHED	Nicaise and Madeleine Avignon founded COFHED in 2001. In September 2002, the Avignons moved to Camp Perrin in southern Haiti and began to explore villages affected by extreme poverty. Lougou was the first village that requested help. In 2003, COFHED began to engage the Lougou community in community-led initiatives to address the spiritual, social, economic, and environmental factors affecting their lives.	The Avignon's are originally from Haiti and have been friends of NTFP since its inception. They have been strong supporters of this project and have served ongoingly as consultants and advisors.
Columbia University	The Earth Institute and the greater Columbia University community have a longstanding commitment to the social and environmental issues affecting Haiti, the Caribbean, and other regions facing similar economic and ecological situations.	Working in conjunction with the Haiti Regeneration Project and the Cote Sud Initiative (both sponsored by Columbia University), we have shared information regarding our experience in the region and plan to collaborate on future projects such as using solar energy to power KTNY.

The Challenges and Strategic Agenda

1. Financial: Inherent in any project of the size, magnitude and quality we strive for, is sustainability of financial resources. To date this has not been an issue, as Jeff and Michele Boston have made a majority of the contributions. At this time, however, with brick and mortar as well as programmatic considerations nearing completion, emphasis will be on acquisition of funding and financial support.

2. Inability to predict the numbers of patients to be served: The clinic lies in a catchment area of approx. 60,000 people, half of whom No Time For Poverty (NTFP) believes to be children. However, in light of the fact that there are no specialized pediatric services west of Port Salut, nor east, until Port au Prince, it is expected that it will be necessary for the clinic to receive children in excess of those who reside within the catchment area. Of further consideration is that Port Salut lies some 45 minutes by vehicle from Les Cayes, Haiti's third largest city and expects to draw heavily from that region.

3. Crowd Control: Medical care in the region is scarce at best. Moreover, there is no facility that specializes in pediatrics in the half of Haiti in which our clinic resides. The nearest pediatric hospital is in Port au Prince - more that four and one half hours away from Port Salut by automobile.

While NTFP have a fair estimate of the numbers of children residing within our region, it is expected that vast numbers outside of the region will seek for their services, thereby presenting the likelihood of crowds will depend on their capacity to serve – at least during the first months of operation. Towards this end NTFP have established a number of safeguards to prepare for this eventuality.

> 1. Vehicles must pass through security and a locked gate prior to reaching clinic grounds.
> 2. Individuals on food will enter through a single file controlled doorway.
> 3. Triage will assure that the most critical children are seen first.
> 4. Children with minor concerns (requiring acetaminophen or less) will be treated at triage - located outside the clinic itself – thereby minimizing congestion and backlog.
> 5. Information regarding clinic hours will be related via NTFP's weekly radio show.
> 6. Ample security will be provided outside and within clinic compound walls.
> 7. Overage will be continually assessed and considered in future planning and development.
> 8. A full week of "trial runs" will be conducted with children of our staff, friends, and Port Salut proper.

4. Lack of skilled nurses trained in pediatrics: Quality medical care in a pediatric clinic/hospital setting is best delivered via nurses skilled in pediatrics. This is especially so for children often too young or without the ability to convey symptoms.

NTFP thorough search for nursing candidates skilled or experienced in pediatrics indicates that such individuals are scarce or unavailable in our region. To address this lack of specialized nursing personnel NTFP will do the following:

1. Develop a specialized pediatrics-training curriculum.
2. Translate the curriculum into French and Kreyol.
3. Teach the curriculum.
4. Comprise multiple teams of American volunteer doctors and pediatric nurses to teach via demonstration, observation, practice, and feedback.
5. Revolve teams so as to supervise and monitor Haitian nurses towards achievement of pediatrics expertise.

5. Lack of skilled nurses trained in triage: Quality medical care in a clinic/hospital setting is best delivered via triage to screen and assess levels of care required. This is especially so for children often too young or without the ability to convey symptoms.

NTFP thorough search for nursing candidates skilled or experienced in triage indicates that such individuals are scarce or unavailable in our region. To address this lack of specialized nursing personnel we will do the following:

1. Develop a specialized triage training curriculum.
2. Translate the curriculum into French and Kreyol.
3. Teach the curriculum.
4. Comprise multiple teams of American volunteer doctors and triage nurses to teach via demonstration, observation, practice, and feedback.
5. Revolve teams so as to supervise and monitor Haitian nurses towards achievement of triage expertise.

6. Limited referral sources: While the clinic will offer a wide array of services, NTFP recognize that a number of medical specialties (i.e. Orthopedic, Neurology, etc.) are unfortunately most often unavailable in Haiti and in the few instances in which this not be the case, are likely cost prohibited.

7. “Competition” with traditional healers: There is a tendency in Haiti to first seek treatment for medical conditions from local Houngans and Mambos. While NTFP have begun to develop relationships with these healers, they look into developing a complementary association with them.

Program Evaluation
NTFP actual methodology

The NTFP capstone team discussed with the organization the continual need for evaluation of NTFP's programs. NTFP considers that this will be a paramount in their programs and critical in reducing the infant, child, and adolescent mortality in the region of Port Salut. NTFP defines their evaluation proposal as "data driven". By this they refer to two primary things: Monitoring and valuation.

The NTFP capstone team based in its research from interviews with institutions like USAID and other subject matter experts in this area like Brian Foster, Owner and Founder of Insight Enterprise Consulting, evaluates that it should be more than this. This research concluded that in addition to a system of record keeping, it is necessary to establish a defined set of Measures of Success or Key Performance Indicators, which can easily monitor program performance and evaluate the level of advance in their main objectives. In establishing these metrics, NTFP will be creating short and long term goals for each of their programs in order to achieve their long-term objectives.

In this Organizational Profile's section we will describe the actual methodology selected by the organization and in the Recommendation and Conclusions the team will expand the concept of "Program Evaluation".

NTFP Program Evaluation:

A paramount consideration deemed critical in reducing the infant, child, and adolescent mortality in the region of Port Salut is that program development and implementation be research based and data driven.

By "data driven" we refer to two primary things: monitoring and evaluation. Monitoring refers to the annual assessment of our program and as such will be built into daily program management via basic record keeping systems; staff in the clinic will be responsible for monitoring the daily activities of the hospital. Health agents and mother's groups will maintain records pertaining to the 0 – 5 Outreach Program, and the trainers will monitor the education components of the program. In addition to collection, maintaining, and collating information to monitor our program, certain features of it will be evaluated over time by persons outside of the daily functioning of the clinic, i.e. academia.

The processes of monitoring and evaluation will provide mechanisms to show us where we are and how to get to where we want to be. Some of the benefits of monitoring and evaluating our program are to:

- Provide feedback as to the effectiveness of the program (and various aspects of it) over time.

- Enable us to identify and stay focused on our goals and objectives.

- Provide an opportunity for the community to participate in yet another key aspect of the program.

- Serve as the basis for No Time For Poverty and the community to tweak, revamp, and/or redefine program objectives and practices.

- Provide confirmation to donors that their money is spent wisely and well.

- Offer the government of Haiti a means of accountability.

We are committed not only to a data driven model but to a transparency of results; positive findings will be celebrated with the community; negative ones will be shared openly and honestly, without blame or criticism, with the community, No Time For Poverty staff, and donors. Negative findings will be considered guideposts for improvement to assure that the effectiveness of our program is maximized in everything we do.

We appreciate that we lack both the expertise and experience to create those systems to monitor and evaluate our work. Therefore it is imperative that we partner with an educational institution with the know-how, personnel, and resources to effectively do so. We are proud to be developing such a relationship with a variety of departments at the University of Minnesota.

Financial Information

Clinic Start-up Period, January 1 2012, March 31st 2012

The startup period will involve setting up equipment, stocking materials and supplies, hiring medical and support staff, and initiating out-patient services. Initial medical staff will include: Physician/Medical Director, 2)full-time Physician, 3) Registered Nurses, 4) Pharmacy Technician, 5)Laboratory Specialist, 6)Nurse's Aide. Support staff will include: 1) Clinic Administrator, 2) Receptionist, 3) Inventory and Bookkeeping person, 4)Building and Groundskeeper, Part-time Drivers, 6) Part-time Interpreters, 7) Housekeeper, 8) Security People, 9) Part-time Housekeeper for Dormitory.

Cost projections for period January to March 2012 (salary projections based on pay schedule provided in attachment).

Item	Amount
1. Salaries and Wages	$88,250
2. Payroll Taxes (10% salaries & wages)	$ 8,250
3. Medications/Medical Supplies	$10,000
4. Building/Grounds Maintenance	$ 6,000
5. Non-Medical Supplies	$ 1,500
6. Food ($5.00/day/person x 30 people)	$13,500
7. Vehicle Travel	$10,000
Other Travel (airfare)	$15,000
8. Generator Fuel	$ 6,000
8. Various expenses	$10,000
Total	**$168,500**

Cost Projections Fiscal Year 4/1/2012 — 3/31/2013

Projections are based on the assumption of all services (o.p. clinic, out-reach, health education) fully operating. This includes all staff identified in the start-up budget plus: 1) Two full-time interpreters, 2) additional 2Y time driver, 3) medical intern, 4) director of outreach services and five outreach agents, 5) part-time maternal health educator. The travel, food, medications, supplies budgets increased to reflect increases in service utilization and costs of supporting University of Minnesota Pediatric Residents.

Item	Amount
Salaries & Wages	$491,000
Payroll Taxes	$ 49,100
Medications/Medical Supplies	$150,000
Building/Grounds Maintenance	$ 25,000
Non-Medical Supplies	$ 8,000

Food	$ 56,000
Vehicle Travel	$ 40,000
Other Travel	$ 20,000
Generator Fuel	$ 24,000
Equipment Repairs	$ 24,000
Building Depreciation (lmISOyr)	$ 20,000
Vehicle Depreciation (125k15yr)	$ 25,000
Equipment Depreciation (200k/5yr)	$ 40,000
Total	**$972,100**

Fiscal year 4/1/2013 — 3/31/2014 projected costs arrived at by adding 10% to previous year projections.

1.10 x $972,100 = $1,069,310

Fiscal years 3, 4, & 5 projected costs based on 10% inflation factor as well.

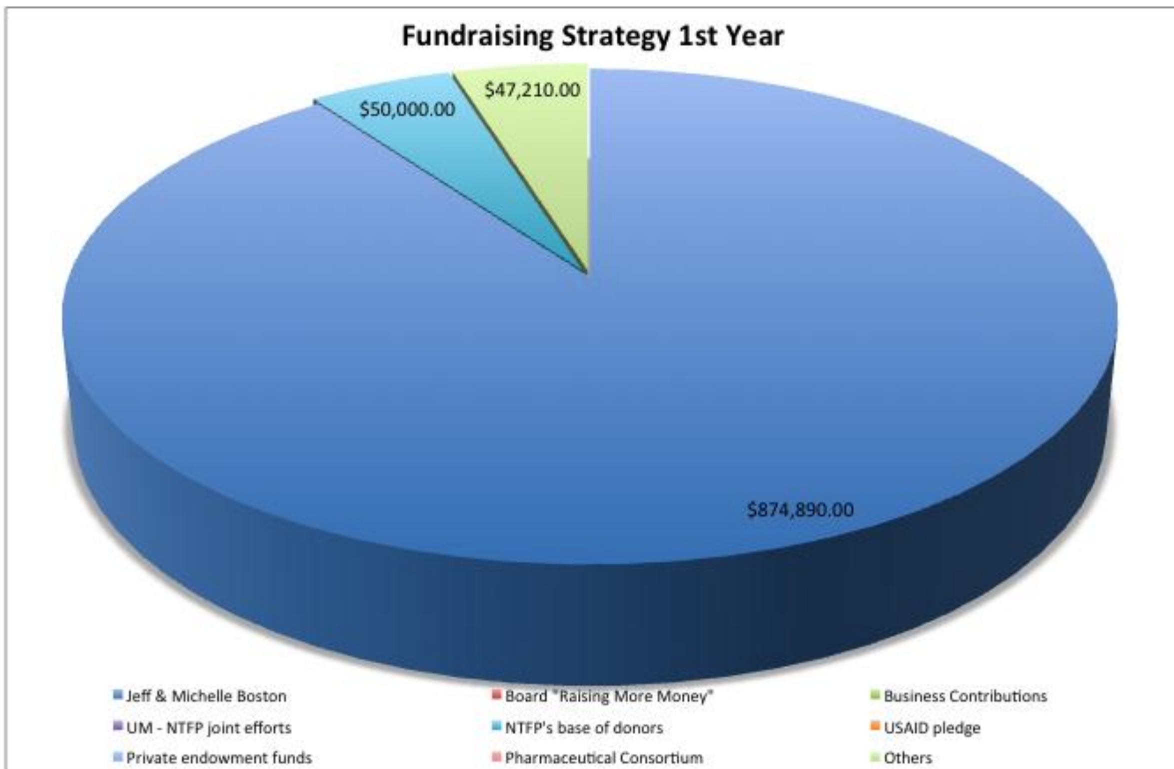
Year3: 1.10 x 1,069,310 = $1,176,241
Year4: 1.10 x 1,176,241 = $1,293,851
Year5: 1.10 x 1,293,851 $1,423,251

Note: Capital costs for clinic building, dormitory, and equipment are paid for prior to opening. Depreciation costs will allow for equipment replacement and building improvements as these costs arise.

Revenues for clinic operations for the first 15 months (January 2012 – March 2013) are projected to come from: 90% Jeff & Michelle Boston, 10% fundraising efforts currently being implemented by No Time For Poverty staff and Board members.

Revenues for operations for fiscal year 2013 – 2016 are projected to come from:

2013	80%	Jeff & Michelle Boston
	20%	Fundraising
2014	60%	Jeff & Michelle Boston
	40%	Fundraising
2015	40%	Jeff & Michelle Boston
	60%	Fundraising
2016	100%	Jeff & Michelle Boston



<u>Current fundraising efforts include the following:</u>

1. Implementing the "Raising More Money" system that requires each board member to hold meetings with eight to ten people of their choosing; present the goals of NTFP sponsored activities: invite all persons to a brunch to be held I November 2011 where each person will be expected to make a pledge for on-going financial support of the clinic's services. The focus and goal of this effort is to establish a base of perpetual annual donors. NTFP hopes to add one hundred to a hundred and fifty new donors to our base of two hundred donors giving between $500.00 - $1,000.00 annually. This approach to fundraising will likely be on-going as fundraising function of the board.

   $250,000 Annually

2. NTFP is currently working with a number of business to solicit monthly donations from employees with company matches.

   $50,000 – 100,000 Annually

3. NTFP will be working with the University of Minnesota Medical School to raise funds for our joint efforts in providing clinical services.

   $100,000 – 200,000 Annually

4. NTFP's current base of donors provides $150,000 annually

5. NTFP is seeking grants from USAID and other institutions:

   $250,000 – 400,000 Annually.

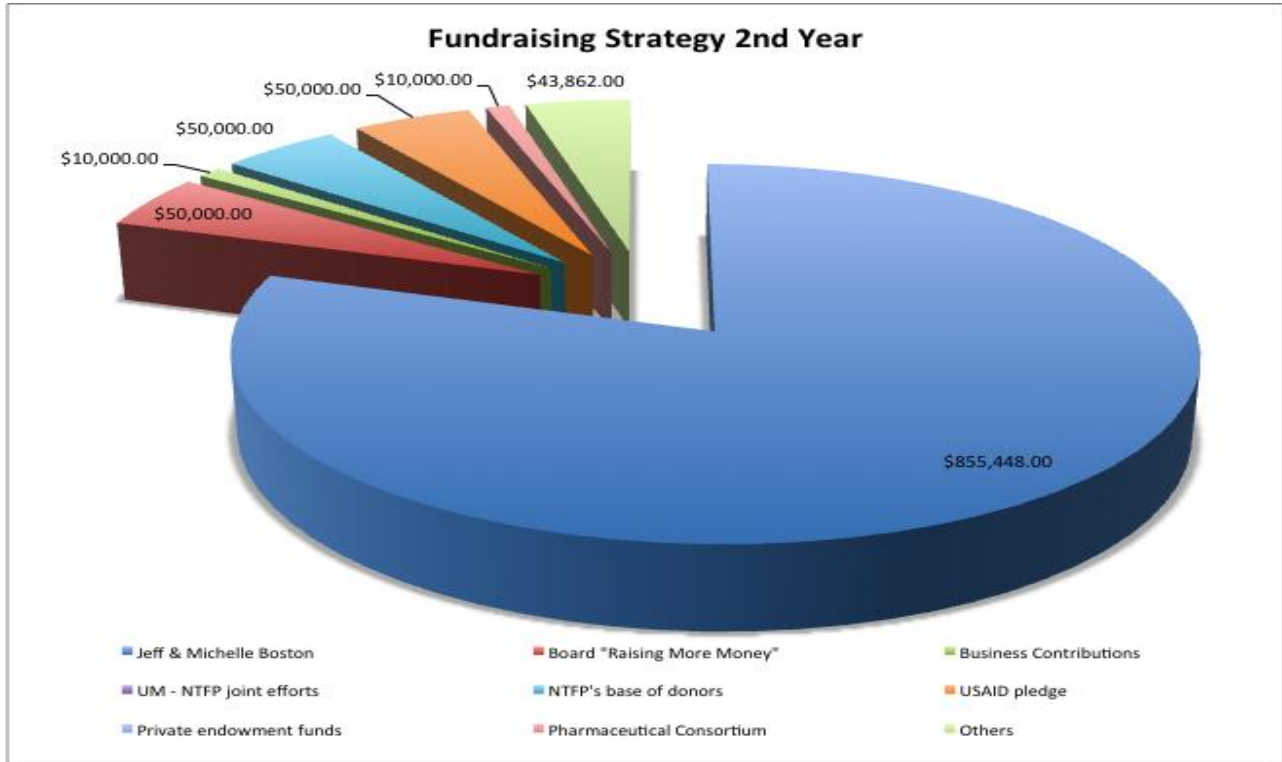
6. NTFP is in discussions with individuals that have expressed interest in our project and may want to help us establish an endowment fund. The five year goal is to build endowments to $5,000,0000, generating $200,000 – 250,000 annually for clinic operations.

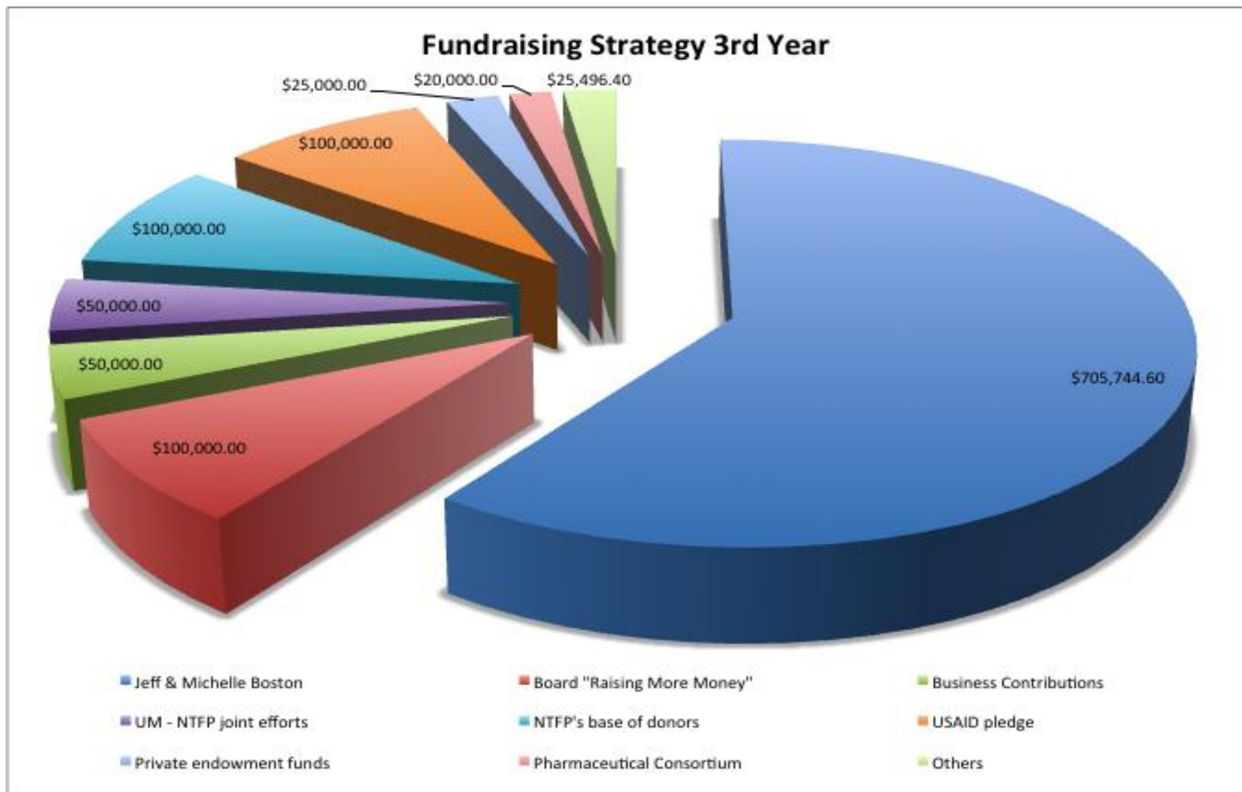
7. NTFP is currently building a consortium of pharmaceutical and medical supply companies that will donate the majority of clinic medications and supplies.

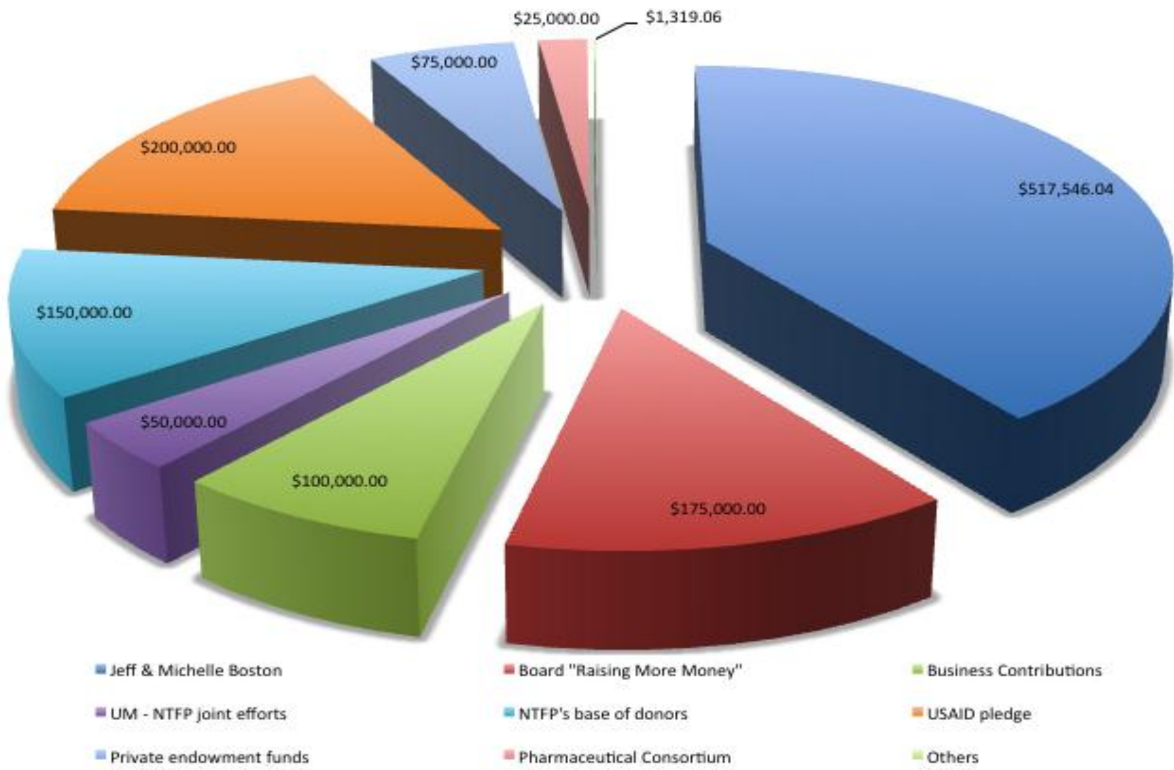
   $100,000 Annually

   NTFP will continue to develop a donation base as an on-going function of the organization. A major part of this effort will be to form partnerships with other organizations that have a shared interest in the well being of Haiti. This will allow us to share costs of services and raise funds for operations.

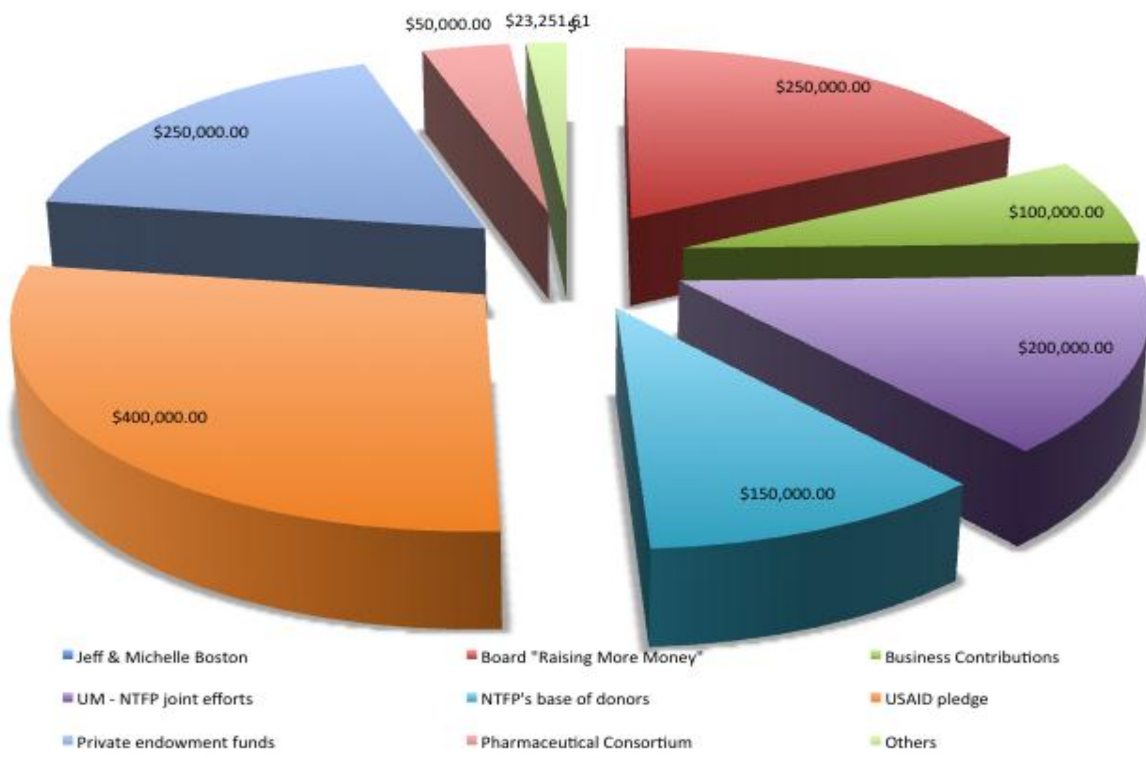
Fundraising evolution







Fundraising Strategy 4th Year
$25,000.00
$1,319.06
$75,000.00
$200,000.00
$517,546.04
$150,000.00
$50,000.00
$100,000.00
$175,000.00
Jeff & Michelle Boston
Board "Raising More Money"
Business Contributions
UM - NTFP joint efforts
NTFP's base of donors
USAID pledge
Private endowment funds
Pharmaceutical Consortium
Others



Fundraising Strategy 5th Year
$50,000.00
$23,251.61
$250,000.00
$250,000.00
$100,000.00
$200,000.00
$400,000.00
$150,000.00
Jeff & Michelle Boston
Board "Raising More Money"
Business Contributions
UM - NTFP joint efforts
NTFP's base of donors
USAID pledge
Private endowment funds
Pharmaceutical Consortium
Others

Recommendation and Conclusions

Recommendations for NTFP

As we conclude our research, the NTFP capstone team offers several suggestions and recommendations for our client, No Time for Poverty (NTFP). After conducting multiple interviews with non-profit organizations, medical, academic and industry professionals we are confident in our research and recommendations and that when implemented will provide valuable inputs to NTFP's strategic, financial and organizational development.

1. Fundraising Strategy:

Our client has agreed and is supportive with our research that NTFP's primary objectives are to begin development strategies for raising significant donations for their organization.

   a. Our first recommendation is to hire an experienced development director. This director should be well versed in international grant writing have worked with or obtained USAID funding and is confident in implementing a successful development campaign, and have a documented success rate of at least 80% in previous projects. According to Indeed.com, the salary of an experienced development director is approximately $78,000 http://www.indeed.com/salary/Director-of-Development.html

   b. Secondary recommendations include inviting development interns from the UMN Humphrey School's Master of Development Practice program to their organization. We recommend implementing this as soon as possible to assist NTFP in developing this campaign.

   c. Our research for NTFP also contains tangible materials that are available for immediate use, which can be directly applied to their fundraising objectives. The NTFP capstone team has created four program descriptions to be used for a multitude of grant applications for which they may be applying. Each template was created based on the programs NTFP has established. These templates are listed as follows:

      I. *Klinik Timoun Nou Yo*
      II. *Breast Feeding*
      III. *Maternal Health*
      IV. *Community Outreach Health Care Program.*

These documents have been prepared in a matter that NTFP may easily extract the information as necessary to respond to an RFP or submit an application for a grant. ***It should be noted that the data will change as the clinic expands and this information can be easily updated.*

d. Most of NTFP monetary and in-kind donations will be generated through a grant wring process. **For clarity and tracking purposes, we recommend creating a template of foundations that are appropriate to submit an application or proposal to.** Creating a grant matrix to observe which foundations are offering funding to similar projects and submitting grants (see appendix for example).

e. To continue with our recommendations; we have created a suggested outline of NTFP's fundraising plan, based on the projected number $972,100. We recommend creating a strategic plan on how and to obtain donations for the upcoming year. Listed below are suggested avenues to pursue for donations opportunities and in kind donations:

Fundraising Strategy/Activities

1) Implement Funding Raising Goal for 2012-2013 (replicate in total info system) (Estimated $972,100)

2) Define sources of the funding
   a) Government
      i) Local in Haiti
      ii) International (US, Brazil, Venezuela, Europe, others)
   b) Helping agencies (USAID, etc.)
   c) Private Foundations (Bush, McKnight)
   d) Individual donations
      i) Bank account
      ii) Website
   e) Fundraising activities
      i) Dinners/ Events
      ii) Others
   f) Media Strategy
      i) Magazines/ Print Ads
      ii) Internet: Social Media i.e. Facebook, Twitter
      iii) Film documentary of clinic- use this on website and at Fundraising events.
   g) In Kind Donations
      i) Medical Equipment Companies.
         (1) Sonosite
         (2) General Electric
   h) Medical Supplies
      i) Local Hospitals
      ii) Health East
      iii) Regions
      iv) University of Minnesota
      v) Pharmaceutical Companies
         (1) Bayer
         (2) Glaxo Smith Kline

(3) Pfizer
(4) Johnson and Johnson

f. Email: At this juncture we recommend more frequent and aggressive emails to existing client base of 900 contacts in Total Source. By aggressive, we insinuate that NTFP should begin asking for donations in their email campaigns. In addition, bi-weekly progress reports reflecting the updates and progress of the clinic will remind existing and potential donors of NTFP's work and mission.

g. Indicate progress on the website of the clinic reflected on the website. It will be helpful to indicate/ mention how your client's donation is helping.

h. Formalize an strategy to obtain USAID funding**:**

There are two ways to apply for USAID funding, the first is to be invited through an RFP, the second is to apply independently. **The most effective way to obtain USAID funding at this juncture is to create partnerships with organizations that are already receiving USAID funding and receive a sub-grant with them.**

As part of our work we met with Brian Foster, an expert in working internationally with organizations to obtain funding. Mr. Foster recommends that it would be advantageous for NTFP to meet with organizations that are looking for partnerships to collaborate with the "Feed the Future" initiative in Haiti, and suggested this could be a substantial partnership for funding opportunities. "Feed the Future" is one of the largest USAID initiatives in Haiti over the next five years. We recommend that NTFP programs include a substantial amount of data that reflect and measure sustainability and growth that is conductive with "Feed the Future's objectives. (see reference below)

> http://www.feedthefuture.gov/countries
> "*Over the next five years in Haiti, Feed the Future aims to help an estimated 567,000 vulnerable Haitian women, children and family members—mostly smallholder farmers—escape hunger and poverty. More than 176,000 children will be reached with services to improve their nutrition and prevent stunting and child mortality. Significant numbers of additional rural populations will achieve improved income and nutritional status from strategic policy engagement and institutional investments." (Feed the Future, website).*

We have also met with Chavanne Peercy, a Professor of International Development at the Humphrey School of Public Affairs. Professor Peercy also recommends creating partnerships for 'sub-grant' opportunities. For example, USAID generally funds regions based on major relief needs, and need to find out where USAID is already funding the Port Salut region and to create relationships with these organizations. Peercy stated that the Minister of Health in Haiti will be instrumental in locating and receiving USAID funding. Furthermore, new USAID requirements mandate that grant

recipients select partners to help fulfill their mission. Partnering with similar organization is now contingent upon being the initial grant recipient.
http://pdf.usaid.gov/pdf_docs/PNADN584.pdf

Another opportunity for NTFP to partner with is, “Health through Walls”, a recipient of USAID funding who is also working on programs that reduce and control contagious diseases. NTFP could try and obtain a 'sub-grant' through “Health through Walls” for any portion of the clinic that works with managing contagious diseases.

Professor Peercy and Mr. Foster agree that the process is much less demanding to partner with an agency for a sub-grant.

i. Going forward it will be imperative for NTFP to maintain and strengthen relationships with their partners in Haiti including local government, especially the Minister of Heath. The most effective way to obtain USAID funding is to build and maintain relationships with the Country Director of these programs. ***Provided sample Feed the Future USAID Presentation (See appendix)*

j. Other recommendations include continually check the website for funding opportunities http://idea.usaid.gov/ls/dgp and sign up for the paid service of Follow Grant Notifications: such as Grant Station.

2. Professionalize No Time For Poverty:

NTFP is a magnificent creation of their founders, which through this organization are helping thousands of families to have better health, better lives and in total a more dignified life. However as it is expressed in their fundraising strategy, NTFP has been primarily funded and supported by Jeff and Michelle Boston, with their involvement in all the aspects of the organization. However the organization needs to move from this stage to a new professionalized one where NTFP can become sustainable and without the constant support of their original founders.

By “professionalization” we refer to the process by which an organization acquires a hierarchical division between the knowledge owners and the directors of the organization. In this professionalization we include the delegation of tasks and authority to the personnel of the organization in accordance with their roles and responsibilities. The professionalization process also has the objective of establishes the group norms of conduct and qualifications that will become the body of the organization behavior.

In this process we include the following actions:

- Institutionalization of a formal organizational chart with clear definitions of roles, responsibilities and reporting lines.
- Definition of a corporate budget with allocations and funds by area and different initiatives.

- Creation of a clear set of rules and guidelines that will define the organization's behavior and help to build the culture of the organization.

3. Partnerships Strategy

This recommendation is common to the vast majority of non-profit organizations that work in difficult environments to help a targeted population to achieve better standards of life. All of these organizations compete for the same resources: People and institutions with the willingness and means donate to help perform activities and achieve objectives. Without these contributors non-profit organizations would disappear and their objectives would remain unfulfilled.

NGO's and non-profits cannot live in isolation and compete with one other to obtain the resources that they need. Especially in the recent economic environment, non-profit organizations in addition to their strategies to achieve their objectives also need to have a strategic alliance approach developed in order to survive in the long term and become sustainable. **Our recommendation to NTFP is to continue working in this strategy in order to transform this initiative into a sustainable and long lasting organization.**

In the partnerships section we have described how NTFP has utilized the collaboration of many similar organizations to overcome different situations that were needed to create and operate the clinic. **It is vital for the future of the organization that similar alliances be created with a variety of governmental and private institutions to sustain the organization and to achieve their objectives.** Each of the described sectors can contribute with different resources that will be fundamental for NTFP. We asked ourselves throughout our research: Can a health institution operate without having a link to other health organizations inside or outside of Haiti? "Partners in Health", the organization created by Paul Farmer twenty years ago, has partnered in different moments with the WHO, Harvard University and hospitals in Boston to fight against tuberculosis and HIV. NTFP will have to find similar ways to sustain their initiative, not only from a fundraising perspective but also from an approach that will be helpful to them to continue their organizational mission. Recommended alliances include: Government, worldwide health institutions, similar non-profit organizations, as well as with private companies willing to fight the same diseases as NTFP.

It is not our intention to dictate which institutions NTFP should select to partner with, but it is our intention to recommend that NTFP start working in this long term strategy as soon as possible as we consider these actions fundamental to the survival of NTFP and the achievement of their objectives.

4. Implementation of a Program Evaluation Methodology

NTFP will monitor and evaluate through a data driven methodology that will be conducted based on very detailed record keeping system. The analysis of this

information will be made in collaboration with the UMN School of Public Health, as it was signed in the Memorandum of Understanding that is attached in the appendix However in our research with different institutions that can provide financial help to NTFP, like USAID or other big grant providers, we found that in addition to a system of record keeping it is also needed to establish a defined set of "measures of success" or" key performance indicators" (KPI's) that can rapidly monitor the performance of the organization and reflect their main objectives. In establishing these metrics NTFP also creates goals that will be key to fulfilling the institution objectives.

Suggested examples of KPI's metrics:

- Quantity of vaccines to be applied in one year.
- Quantity of Health Agents to be trained in one year.
- Quantity of women attending the prenatal trainings.
- Quantity of children deaths in a normal year and same rate after the implementation of the programs.
- Quantity of mothers attended to during their pregnancy and relation with the birth rate in the five communities where NTFP will have influence.
- Use and implement improvement tools and strategies such as PDSA (Plan Do Study Act) as it was recommended to us by Dr. Christine Jones, School of Public Health, University of North Carolina

  http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx

5. Use of Management tools

   In order to fulfill its mission and become what NTFP was created to be, this organization has to apply their skills and use the limited resources that they will have in the future, including budget, people and its assets. Below are list of management tool that will maximize their longterm efforts:

   1) Strategic Planning: in which we include several tools like a SWOT Analysis (Strengths, Weakness's Opportunities, Threats) and a strategic agenda.
   i) Stakeholder Analysis.
   2) Project Portfolio Management
   3) Financial performance follow-ups
   4) Human Resources practices and tools like individual performance management, compensation programs, internal training and development programs and other

Appendix

MEMORANDUM OF UNDERSTANDING BETWEEN REGENTS OF THE UNIVERSITY OF MINNESOTA BY AND THROUGH ITS ACADEMIC HEALTH CENTER AND NO TIME FOR POVERTY SIGNED IN JANUARY 2011.

THIS MEMORANDUM OF UNDERSTANDING (this "MOU"), effective January 1, 2011 through December 31, 2015, documents the arrangement under which No Time For Poverty ("NTFP") and the Regents of the University of Minnesota, by and through its Academic Health Center ("University"), will collaborate in providing educational and research experiences for students, residents and faculty. The purpose of this MOU is to set forth the expectations of the parties.

I. TERM AND TERMINATION

Either party may terminate this MOU, with or without cause, upon at least one hundred and twenty (120) days prior written notice to the other party, or such shorter time as may be agreed to by the parties. The parties agree, however, that if a party identifies concerns that may lead to termination of this MOU, such party will notify the other party as soon as reasonably possible upon identifying such concerns and the parties will work together in good faith to resolve the concerns prior to initiating termination of this MOU. Such notice will be directed to the contact persons identified below or to such other persons as agreed to by the parties. Any notice of termination shall be in writing and delivered to the contacts and addresses set forth below or such other persons and/or addresses as agreed to by the parties. Notices sent by personal delivery or facsimile transmission shall be deemed given upon independent verification of receipt. Notices sent via commercial messenger service overnight delivery shall be deemed given on the next business day_ Notices sent by first-class United States mail shall be deemed given three (3) business days from the date mailed, proper postage prepaid and properly addressed to the appropriate party at the address set forth below or to another more recent address of which the sending party has received notice.

If to NTFP:

Michele Boston
Director
No Time For Poverty
1865 Old Hudson Road
St. Paul, MN 55119

If to University:

University of Minnesota Academic Health Center
Attn: Aaron Friedman, M.D.
Vice President for Health Sciences
MMC 501
420 Delaware Street SE
Minneapolis, MN 55455

II. AMENDMENT

Any amendment or modification of this MOU must be agreed to in writing and executed by authorized representatives of the parties.

III. CONFIDETIAL BUSIESS INFORMATION

The parties acknowledge that during the course of this MOU, each party may learn or receive confidential and proprietary information, including but not limited to trade secrets, business or organizational plans, recruitment files and research protocols, concerning the other party or third parties to whom the other party has an obligation of confidentiality ("Confidential Information"). Confidential Information shall not include information that: (a) was in the receiving party's possession prior to disclosure by the other party; (b) was in the public domain at the time of receipt or becomes a part of the public domain at any time thereafter through no act or omission of the receiving party; (c) was independently developed or acquired by the receiving party 'without reference to any Confidential Information of the other party; or (d) a party receives on a non-confidential basis from a third party, who to the best of the receiving party's knowledge after due inquiry, is not prohibited from discussing such information by a legal, contractual or fiduciary obligation.

The parties agree to take all necessary steps to provide the maximum protection to the other party's Confidential Information, including taking at least such precautions to protect the other party's Confidential Information as the party takes to protect its own Confidential Information. The parties shall not utilize Confidential Information belonging to the other party for any purpose other than performance of this MOU without the prior written consent of the other party. The parties also agree, except as may be required by law, not to disclose each other's Confidential Information to a third party without the prior written consent of the party to whom the Confidential Information belongs. Upon termination of this MOU, a party in possession of Confidential Information belonging to the other party shall either return such Confidential Information to the disclosing party or, if so directed by the disclosing party, destroy the Confidential Information without retaining copies. Each party shall retain sole ownership of its Confidential Information.

If either party is ordered by a court of competent jurisdiction or government agency to produce the other party's Confidential Information, such party shall promptly notify the other party and shall make all reasonable efforts to allow the other party an opportunity to seek a protective order or other judicial relief prior to any disclosure of the requested Confidential Information.

The parties acknowledge and agree that the disclosure of Confidential Information may result in irreparable harm to the non-disclosing party for which there is no adequate remedy at law. The parties therefore agree that in the event a party violates or threatens to violate the provisions of this section, the other party is entitled to seek injunctive relief. This remedy will be in addition to any other remedy available at law or equity.

This Section shall survive termination of this MOU.

IV. FUTURE COLLABORATIONS

The parties anticipate entering into additional written collaborative arrangements related to activities of NTFP and University. This may include, but not be limited to, participation of University students, residents and faculty at NTFP and participation of NTFP at the University. The parties agree that this MOU serves as a broad and general enabling document and agree to execute additional, specific written affiliation agreements, MOU s or such other agreements as necessary to document each such collaboration ("Definitive Agreements"). All such Definitive Agreements originating under this MOU shall be cleared through, and approved and executed by, the signatories to this MOU. The parties agree that any collaborative relationship between NTFP and University is not exclusive and does not preclude either party from entering into similar collaborative relationships with other institutions.

V. COSTS

University and NTFP agree that neither party shall be responsible for costs or expenditures incurred by the other under this MOU. Project proposals, funding strategies and draft definitive Agreements, including the nature, scope and cost of exchanges and cooperation, shall be developed in collaboration with the parties' appropriate authorities.

VI. USE OF NAMES OR LOGOS

The parties agree not to use the name, logo or any other marks (including, but not limited to, colors and music) owned by or associated with the other party or the name of any representative of the other party in any sales promotion work or advertising, or any form of publicity, without the prior written permission of the other party in each instance.

The following representatives have authority to approve this MOU.

Approved by:

No Time For Poverty — Regents of the University of Minnesota

Community Needs Assessment: *Choquette, Marace, LaFerme, Roche Jabouin, Rousseau*

Port Salut, Haiti / July-August, 2010

Performed by *School of Public Health*, *University of Minnesota - August 24, 2010*

Elizabeth M. Lownik
Austin R. Wetmore
William J. Riley

Overview

This report represents a public health survey that was completed in the region of Port Salut, Haiti, in the summer of 2010, for the purpose of providing the organization No Time for Poverty with information regarding the baseline level of knowledge, attitudes, and practices regarding health care practices of mothers of young children in the five localities selected for their public health outreach program: Choquette, Marace, LaFerme, Roche Jabouin, and Rousseau. The survey was adapted from a rapid catch assessment tool that has been validated and vetted in Guatemala and Ecuador through the work of Dr. Therese Zink at the University of Minnesota, translated into Haitian Kreyol. The survey consisted of 58 items under17 health dimensions, including:

- Household Composition
- Immunizations
- Anthropometry
- Maternal and Newborn Care
- Breastfeeding and Nutrition
- Integrated Management of Childhood Illness (IMCI)
- Malaria Prevention
- Family Planning
- HIV/AIDS
- Hand-washing Practices
- Water Quality and Hygiene
- Diet Screening
- Socioeconomic Position/Social Capital
- Mental Health
- Access to Care
- Health Status
- Household Data Observation

401 surveys were completed in an eight-week period, performed by trained community members from the villages surveyed. A systematic sampling method was used in which every third (Choquette, Rousseau, and Roche Jabouin) or every fourth (Laferme and Maurace) house of the entire village was included in the survey sample to obtain an n of statistical significance.

IRB approval was obtained through the University of Minnesota, in June of 2010 as an addendum to the research of Dr. Therese Zink.

The following sections present the results of the 401 surveys in each of the health topic areas covered by the survey.

Survey Results by Health Topic

1. Household Composition

The average age of the mother of the household in all five communities is 45. This ranges from 37 in Choquette to 55 in Maruace, shown in Figure 1. Each mother is accompanied, on average, by 6 other members of the household. Choquette has the least average number of people in the household at 5 with an average of 0.38 children under 5 years old; Roche Jabouin has the most average number of people in the household at 7 with an average of 0.71 children under 5 years old. This is displayed in Table 1 and Figure 2. Table 1 also illustrates the percentage of households in each village that have children under 5, with an average of 33.1%: Choquette was the lowest at 22.1% and Roche Jabouin the highest at 41.4%

Laferme has the highest average number of children under the age of 5 per household at 0.76, shown in Figure 3. For the majority of the communities, most of the children under the age of 5 were female. Laferme was the only community in which there were more male children under the age of 5 than female children. In all of the communities, mothers identified either older children or other relatives in the household as those they most frequently leave children under 5 with for caretaking when they leave the household.

Table 1

	Average Age of Female Head of Household	**Average Number of Persons Per Household**	**Percentage of Households with Children under 5**
Choquette	36.58	4.84	22.1
Rousseau	44.44	6.51	40.2
Maurace	55.01	5.82	23.6
LaFerme	44.41	6.18	39.7

Roche Jabouin	45.44	6.69	41.4
Total	**45.44**	**6.00**	**33.1**

Figure 1

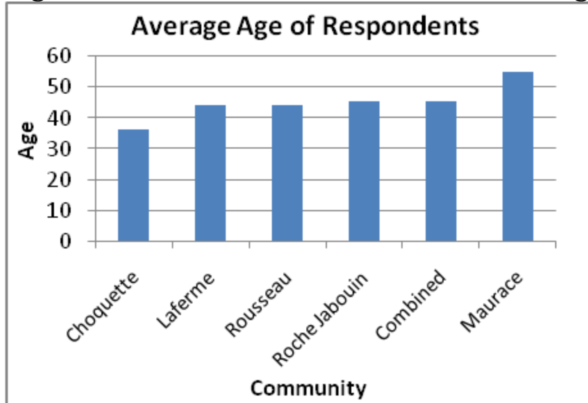


Figure 2

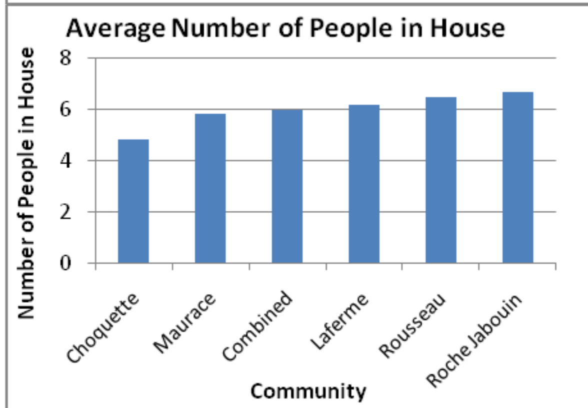
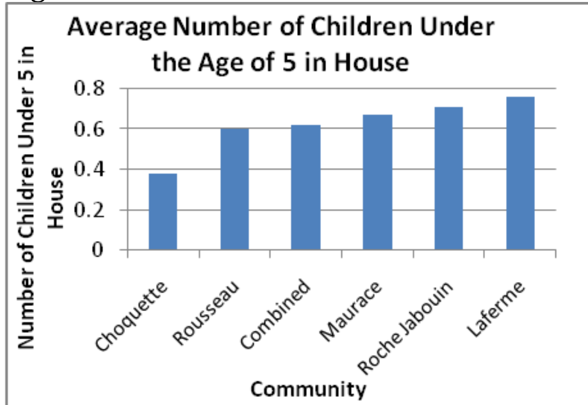


Figure 3



2. Immunizations

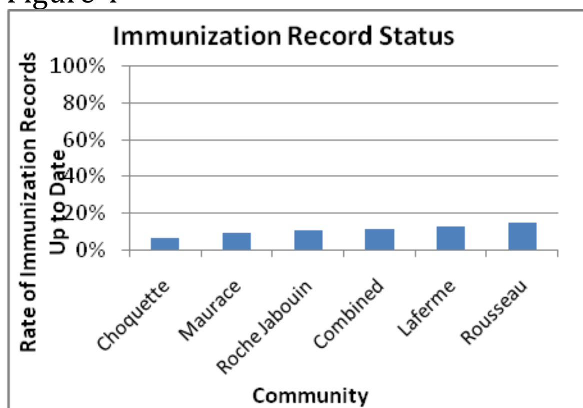
The vaccination records were obtained for each of the children under five in the households surveyed. The percentages of children that have acquired specific vaccines are listed below in Table 2. Between 37.6 and 64.7 percent of the vaccines have been obtained overall in all five villages, with Rosseau showing the highest overall rate and LaFerme the lowest. In addition, the overall percentage of children who had acquired all vaccines recommended by the World Health Organization immunization guidelines for children under 5 years old (N=11 immunizations) within the timeline according to guidelines applicable to the child's age was calculated. The rate of children who have obtained all recommended vaccines within the recommended timelines was low throughout all five communities for children under 5 years of age. **Overall, 11.5% of children under 5 years of age were up to date with their immunizations throughout all five communities. This ranged from 6.7% in Choquette to 14.7% in Rousseau. Table 2 and Figure 4 show the rate of immunization records that are up to date for each community, along with the average rate of all of the communities combined.**

Table 2: Percent of Children Up to Date with Vaccinations

	BCG	DPT1	DPT2	DPT3	P1	P2	P3	RG	**Up to date**
Choquette	58.8	58.8	52.9	52.9	58.8	47.1	47.1	47.1	**6.7**
Rousseau	61.8	79.4	70.6	55.9	76.5	70.6	55.9	50	**14.7**
Maurace	59.1	63.6	54.6	50	54.6	54.6	50	40.9	**9.1**
LaFerme	67.7	58.1	45.2	35.5	58.1	45.2	35.5	25.8	**12.9**
Roche Jabouin	55.2	58.6	51.7	48.3	58.6	51.7	51.7	27.6	**10.3**
Total	**60.9**	**64.7**	**55.6**	**48.2**	**62.4**	**54.9**	**48.1**	**37.6**	**11.5**

BCG=Bacillus Calmette-Guérin
DPT=Diptheria, Pertussis, Tetanus
P=Polio
RG=Rabies

Figure 4



3. Anthropometry

Children under the age of 5 are categorized into three percentile ranges based on their weight for age: below the 3rd percentile (extremely malnourished), between the 3rd and 15th percentiles (malnourished), and above the 15th percentile (within normal limits). The World Health Organization Growth Standard charts provide weight ranges for every age between birth and 5 years of age, as well as percentile lines in order to calculate which percentile range a specific aged and gendered child lies in. On average, 73.3% of children under the age of 5 in the five communities have weights that exceed the 15th percentile and are within normal limits based on the World Health Organization's Child Growth Standards. This is displayed in Figure 5**. 15% of children in all localities fall in the category of malnourished, falling between the 3rd and 15th percentiles. Shown in Figure 6, 11.6% of children in all five localities are extremely malnourished and have weights that are below the 3rd percentile.** This ranges from 0% in Roche Jabouin to 19% in Choquette. The average weight of the children throughout all five communities is 10.4 kilograms. Roche Jabouin has the highest average weight of children at 14.6 kilograms, and Maurace has the lowest at 9.8 kilograms. Figure 7 shows the average weights for all five communities, in addition to the aggregate average weight. Table 3 illustrates the results for each of the five localities and the total as a percentage. Maurace has the greatest overall percentage of malnourished children, and Roche Jabouin has the least.

Table 3

Percent:	Choquette	Rousseau	Maurace	LaFerme	R. Jabouin	**Total**
W/in normal limits	68.8	75.8	47.4	82.1	83.3	**73.3**
Malnourished	12.5	9.1	42.1	3.6	16.7	**15**
Extremely malnourished	18.7	15.1	10.5	14.3	0	**11.7**

Figure 5

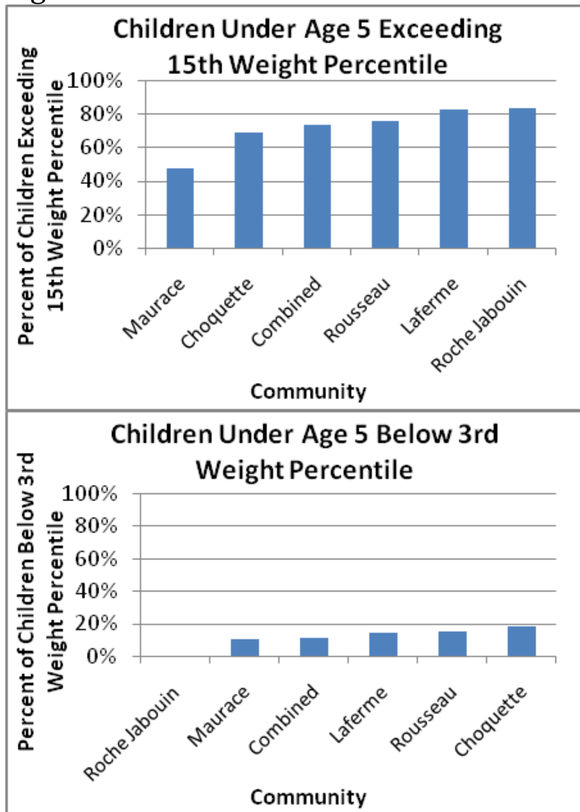
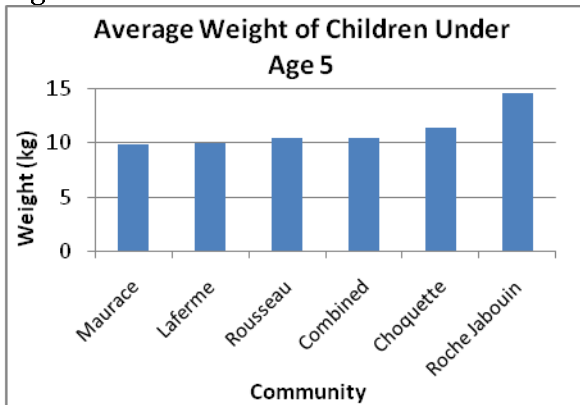


Figure 6

Figure 7



4. Maternal and Newborn Care

Overall, 33% of the respondents to this survey (N=133) are mothers with children less than 5 years of age in the household. Of these, 13% (N=18) reported that they are currently pregnant (this does not include women who are currently pregnant but do not have a child under 5 years of age in the household). 38% of the currently

pregnant women reported that they have received care during their pregnancy (N=8). This is shown in Figure 8 and Figure 9. All female respondents who indicated they are currently pregnant responded to three items regarding frequency and location of prenatal care. Maurace has the lowest percentage of currently pregnant women at 9% (N=2), and none of these women have seen someone for care during this pregnancy. In LaFerme, over 19% (N=6) of the women are currently pregnant, which is the highest percent throughout all five communities, and 67% (N=4) of these women have seen someone for care during their pregnancy. Figure 10 shows that Maurace has the highest percentage of women that have been pregnant within the last two years at 77% (N=17), while Choquette has the lowest percentage of women that have been pregnant within the last two years at 59% (N=10). Of those women that have been pregnant within the last two years in Choquette, their children from those pregnancies are all currently alive (N=10). However, in Laferme, only 91% (N=21) of their children from those pregnancies within the last two years are currently alive. This is shown in Figure 11. The amount of care received during those pregnancies within the last two years varies among the five communities. In Choquette, 100% of the women received care during their pregnancy, but in Rousseau, only 70% (N=23) received care during their pregnancy. This is displayed in Figure 12. Throughout all five communities, the average number of times women who were pregnant within the last two years received care for those pregnancies is 3.3 times.

Figure 8

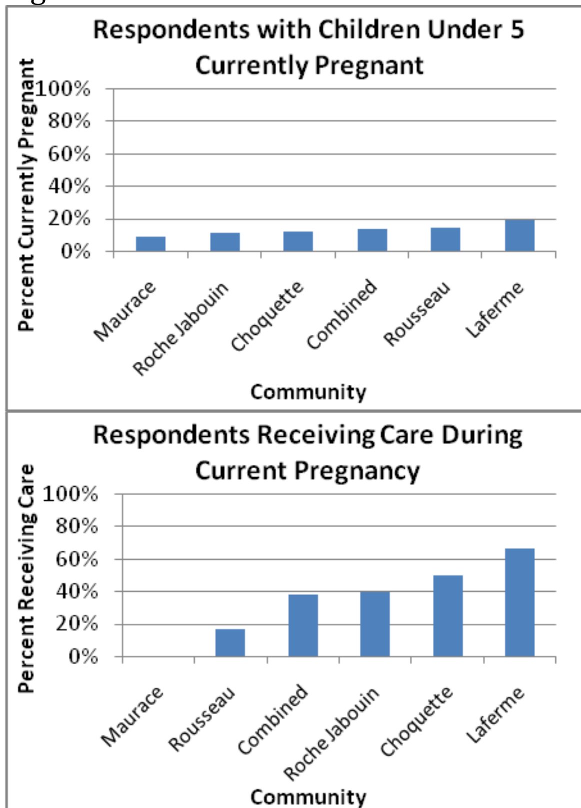


Figure 9

Figure 10

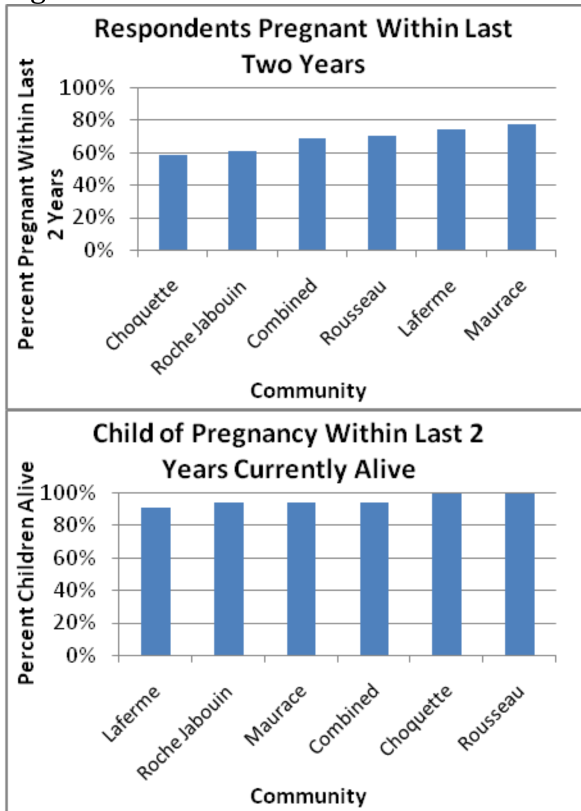
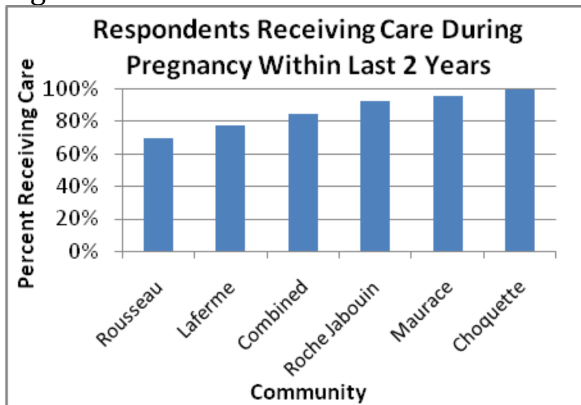


Figure 11

Figure 12



The women that gave birth to a child within the last two years were asked questions about who assisted with the child's delivery. Table 4 summarizes this information by locality. **Throughout all five communities, the majority of the women received assistance from an auxiliary midwife (80%).** Laferme has one mother that did not receive assistance with her delivery. This is the only mother throughout all five communities that did not receive assistance with her delivery.

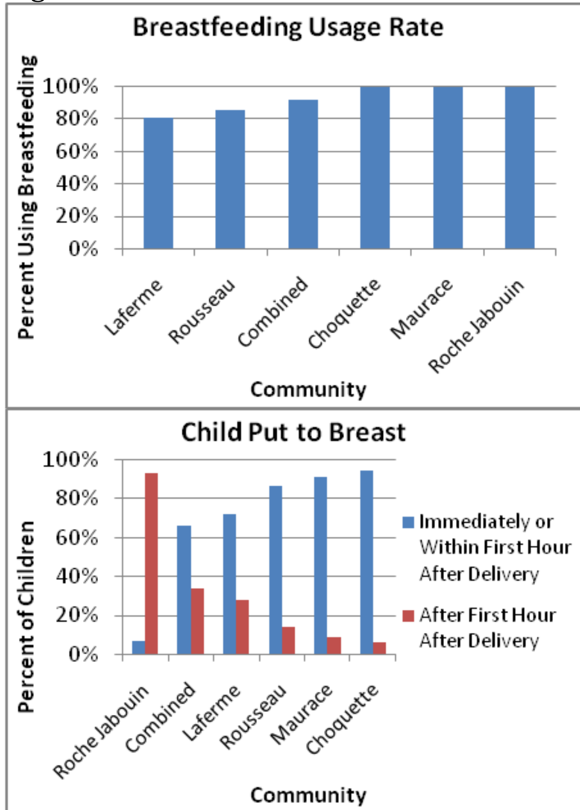
Table 4: Birth Assistant during Last Delivery; Percentage

	Nurse Midwife	**Auxiliary Midwife**	**Doctor**	**Family Member**	**Traditional Birth Attendant**
Choquette	41.2	58.8	0	0	0
Rousseau	2.9	82.3	5.9	8.8	0
Maurace	0	95.5	4.6	0	0
LaFerme	9.7	80.7	6.5	6.5	0
Roche Jabouin	17.2	75.9	13.8	6.9	13.8
Total	**12.0**	**79.7**	**6.8**	**5.3**	**3**

5. Breastfeeding and Nutrition

The mothers of the survey that have children under the age of 5 were asked a series of questions about breastfeeding and the diet of their children. All mothers who indicated they breastfed their child responded to five items regarding the starting period of breastfeeding and other nutrition given to the child. Three of the five communities show a 100% rate of breastfeeding by the mothers to feed their children under the age of five at some point between their birth and the present time: Choquette, Maurace, and Roche Jabouin. Rousseau and Laferme showed rates of 85% and 81%, respectively. This is seen in Figure 13. However, variation exists shown among the communities in regards to when the child was first put to the mother's breast, illustrated in Figure 14 exhibits. The majority of mothers in Choquette, Rousseau, Maurace, and Laferme put the child to their breast immediately after delivery or within the first hour after delivery. However, Roche Jabouin has a 93% rate of mothers putting the child to their breast after the first hour after delivery.

Figure 13 Figure 14



Variation is also seen across the communities in regards to when the child was first given liquid from the mother's breasts. Eighty-four percent of children were given liquids from the mother's breasts during the first 3 days after delivery in Laferme, shown in Figure 15, while only 14% of children under the same circumstances in Maurace. Along the same trend, mothers in Laferme have the highest rate (12%) of giving their children other food or liquids during the first 3 days after delivery before giving breast milk, and Maurace, the lowest (0%). This is displayed in Figure 16. **Across the five communities, the most common nutrition given to the children other than breast milk during the first three days after delivery is plain water, and the percent of mothers that gave plain water to the children exceeded that of mothers that gave breast milk to the children, but only by less than 1%.**

Figure 15 Figure 16

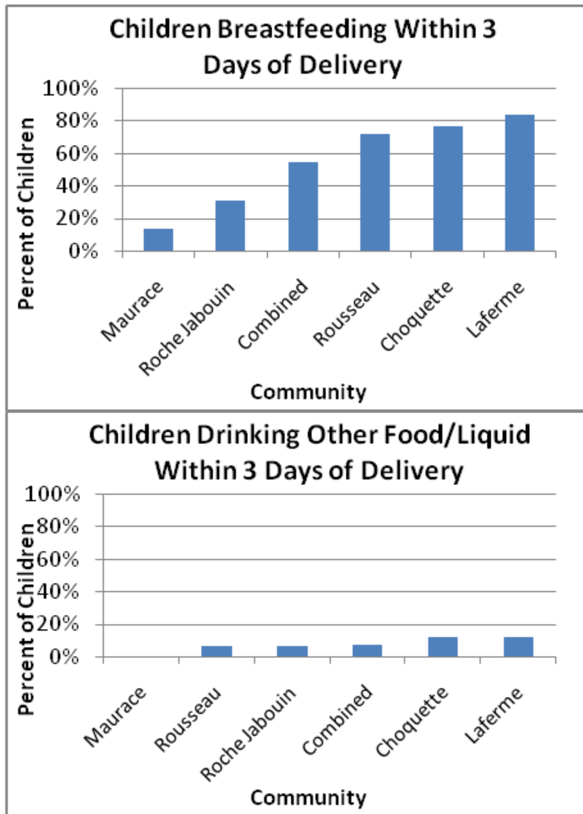
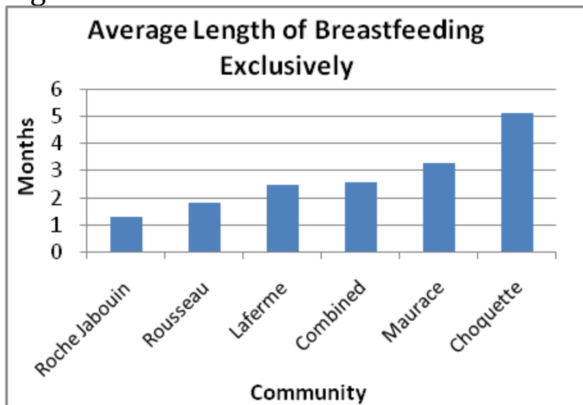


Figure 17 displays the average length of using breastfeeding exclusively, as the only source of nutrition, among the mothers with children under the age of 5. This ranges from 1.3 months in Roche Jabouin to 5.1 months in Choquette. Of note, none of the communities exhibit the WHO recommended length of time for exclusive breastfeeding of 6 months.

Figure 17



All of the mothers with children under the age of 5, including the ones who did not use breastfeeding for their child's nutrition, were asked a series of questions pertaining to the liquids and foods consumed by the child in the last 24 hours.

Eighty percent (N=106) of the mothers from all communities gave their child mashed, pureed, solid, or semi-solid foods within the last 24 hours, with the most common foods being manioc, soup, rice, and bread, respectively. This is the most common nutrition given to the children. The least common nutrition given to the children within the last 24 hours is breast milk at 24% (N=31).

6. Integrated Management of Childhood Illnesses (IMCI)

For the IMCI portion of the survey, the respondents consist of the mothers with children under the age of 5. The women were asked various questions regarding illnesses their children experienced and the mechanisms they chose for management (treatment). Ninety-five percent of mothers from all five communities were able to list some indications of illness in their children without any prompt. The percentage of mothers from each community that know indications of illness are shown in Figure 18.The most common indication of illness listed by the respondents is a high fever (80%). The least common indication of illness listed, at 4%, is lethargic behavior or difficulty waking the child. Other indications of illness included in the survey are: the child looks unwell or is not playing normally, the child is not eating or drinking, the child has fast or difficult breathing, the child is vomiting everywhere, the child has convulsions, or the child has other indications of illness that are not listed in the survey. Table 5 summarizes these results.

Table 5: Percentage of Respondents who independently identified these Indications of Illness

Indication of Illness	Choquette	Rousseau	Maurace	LaFerme	R. Jabouin	**Total**
Don't know any	0	2.9	4.6	9.7	3.5	**4.5**
Looks unwell	41.2	11.8	9.1	19.4	44.9	**24.1**
Not eating or drinking	64.7	14.7	13.6	9.7	55.2	**30.1**
Lethargic	0	5.9	0	0	10.3	**3.8**
High fever	88.2	79.4	86.4	67.7	86.2	**80.5**
Fast or labored breathing	0	5.9	18.2	3.2	17.2	**9.0**
Vomiting	5.9	2.9	27.3	3.2	27.6	**12.8**
Convulsions	17.6	2.9	0	0	6.9	**4.5**
Other	17.7	50	18.2	61.3	55.2	**44.4**

Following the question pertaining to indications of illness, the mothers with children under the age of 5 were asked whether their child experienced any of eight different symptoms correlated with illness within the past two weeks. Coughing and a fever are the two most common symptoms among the five communities with 56% and 53% of children experiencing them, respectively. Eighty-two percent

(N=14) of the children under the age of 5 in Choquette reported having a cough within the past two weeks. 38% (N=13) of the children under the age of 5 in Rousseau reported having a cough within the past two weeks. This is displayed in Figure 19.The least common symptoms recorded among the five communities are malaria and convulsions, each at a 1.5% rate. Other symptoms recorded are diarrhea, blood in stool, difficulty breathing, and fast breathing (or short and quick breaths). Only 6% of children had not experienced any symptoms of illness in the two weeks preceding the survey. Table 6 summarizes these results.

Table 6 Illnesses Experienced by Children in the Past Two Weeks, Percentage of Total

Illness	Choquette	Rousseau	Maurace	LaFerme	R. Jabouin	**Total**
Diarrhea	64.7	20.6	72.7	45.2	31.0	**42.9**
Blood in stool	0	0	4.6	3.2	3.5	**2.3**
Cough	82.4	38.2	59.1	61.6	62.1	**55.6**
Difficulty breathing	5.88	8.82	0	9.68	6.9	**6.8**
Fast breathing	11.8	5.9	4.6	16.1	6.9	**9.0**
Fever	64.7	35.3	54.6	64.5	51.7	**52.6**
Malaria	0	0	0	6.5	0	**1.5**
Convulsions	0	0	4.6	3.2	0	**1.5**
Not ill	0	8.8	4.6	6.4	6.9	**6**

The mothers that reported their child having experienced one of the symptoms listed above were then asked the amount the child was offered to drink and eat while he or she was ill. The majority of these mothers throughout all five communities offered their child both less to eat (85% of mothers) and less to drink (79% of mothers) when their child was ill. Only 4.8% of respondents offer sick children more to eat, and only 2.4% of respondents offer sick children more to drink.

Figure 18

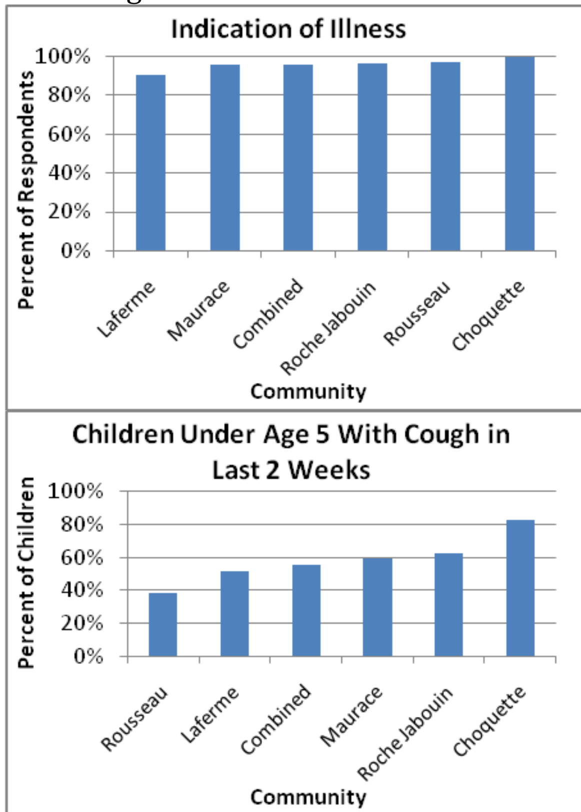


Figure 19

86% of the mothers across all five communities first went to a hospital or clinic when their child was ill; 100% of mothers in Choquette did so. Eighteen percent of the mothers in Laferme did not seek any treatment when their child was sick, with an average of 10% not seeking treatment across the five communities. Four percent of the mothers went to a traditional healer to seek treatment for their child, and no mothers sought care from a community health worker or a friend or family member. In the majority of those households (86%) with an ill child within the past two weeks, the mother of the ill child decided where to take the child for care. The husband is the next most common decision maker of where to take the child for care, at 27%. Of those who sought care for their child at a hospital, 94% of them throughout the five communities did indeed have to pay for it. This ranged from 100% in Choquette (N=17) to 88% (N=23) in Roche Jabouin and is displayed in Figure 20. The mothers who paid for the consult were then asked the amount they had to pay for it. As shown in Figure 21, the average amount across all five communities is 492 Haitian gourdes, ranging from 320 in Maurace to 560 in Choquette.

Figure 20

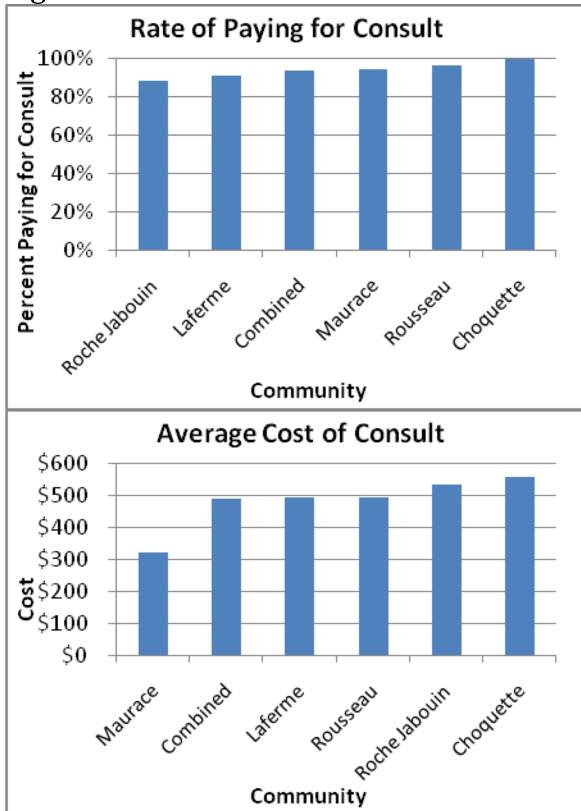
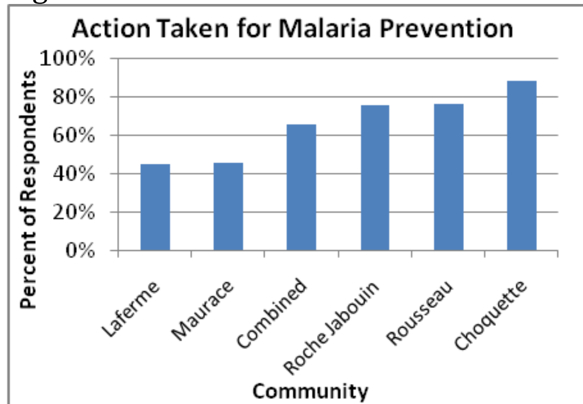


Figure 21

7. Malaria Prevention

All mothers with children under the age of 5 responded to three items regarding the cause and prevention of malaria. The most frequent response to the cause of malaria throughout all five communities is mosquito bites. One hundred percent of the respondents from Choquette know that mosquito bites cause malaria. However, only 52% of respondents from Laferme indicated that mosquito bites cause malaria. In Choquette, 88% of respondents have taken action to prevent malaria, while in Laferme and Maurace; only 45% have taken action to prevent it. This is shown in Figure 22. The most common response to the method that prevents malaria is fire and smokes to ward away the mosquitoes. Fifty-nine percent of respondents across the five communities indicated that this is an effective method to prevent malaria. Of note, only 5.7% of respondents recognized bed nets as a way to prevent malaria, and only 11.4% recognized that draining collected water in open containers. Other methods mentioned are spray, coils, bed nets, and drains or the act of covering exposed water.

Figure 22



8. Family Planning

All mothers with children under the age of 5 responded to five items pertaining to their current and past use of methods of family planning. When asked to identify methods that can be used to prevent unwanted pregnancy, 57% listed condoms, 48.9% listed oral contraceptive pills, and 50.4% listed depoprovera injections. Very few identified intrauterine devices, the rhythm method, or the withdrawal method. Table 7 summarizes these findings.

Table 7: Percentage of Respondents who Identified Methods to Help Avoid Pregnancy

Method	Choquette	Rousseau	Maurace	LaFerme	R. Jabouin	**Total**
Condoms	94.1	44.1	59.1	41.9	65.5	**57.1**
OCP	47.1	26.5	63.6	38.7	75.9	**48.9**
Depo	35.3	50	54.6	41.9	65.5	**50.4**
IUD	5.9	0	0	3.2	0	**1.5**
Rhythm	0	2.9	0	6.5	27.6	**8.3**
Withdrawal	0	0	0	6.5	3.5	**2.3**

OCP=oral contraceptive pills
Depo=depoprovera injections
IUD=intrauterine device

Use of a family planning method by the mothers varies among the five localities. In Choquette, 76% of respondents indicated they have used a family planning method before, and 92% indicated they are currently using a family planning method. However, in Laferme, a mere 6% indicated they have used a family planning method before. Currently, only 29% of respondents from Rousseau are using a family planning method. This is seen in Figure 23. Use of the different types of family planning methods also varies among communities. The most common type of family planning method used throughout the five communities in the past, as well as currently, is condoms. Variation is seen in the use of condoms between

communities and this is displayed in Figure 24. One hundred percent of respondents in Maurace who currently use family planning are using condoms. Zero percent of respondents indicated the use of condoms in Laferme for both past and present; however, 50% of women in Laferme had been on oral contraceptive pills in the past. Zero respondents from any of the five communities indicated use of IUD, either in the past or present. Table 8 summarizes the chosen methods of those currently using family planning.

Figure 23

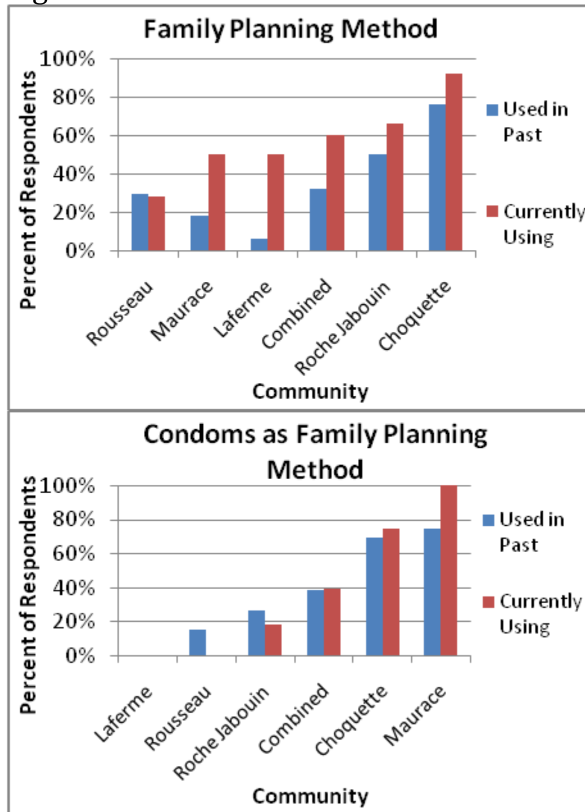


Figure 24

Table 8: Percentage of Respondents Currently Using Family Planning by Selected Method

Method	Choquette	Rousseau	Maurace	LaFerme	R. Jabouin	**Total**
Condoms	75	0	100	0	18.2	**39.4**
OCP	16.7	16.7	0	0	27.3	**18.8**
Depo	8.3	33.3	0	0	45.5	**25**
IUD	0	0	0	0	0	**0**
Rhythm	0	0	0	0	0	**0**

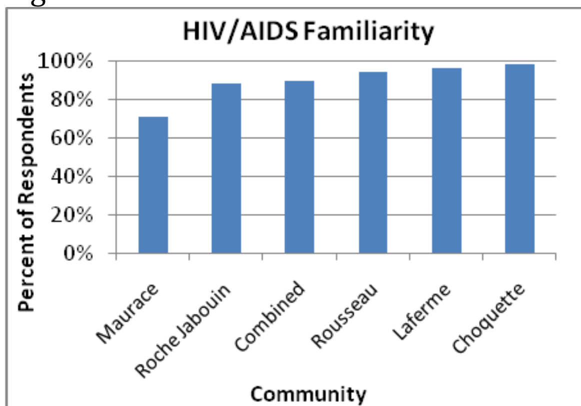
Withdrawal	0	0	0	100	0	**3**

OCP=oral contraceptive pills
Depo=depoprovera injections
IUD=intrauterine device

9. HIV/AIDS

Every woman given the field survey tool answered items pertaining to HIV and AIDS. An overall of 90% (N=358) of respondents heard of AIDS before. This ranges from 99% (N=76) in Choquette to 71% (N=62) in Maurace, and is shown in Figure 25. Respondents who indicated they have heard of AIDS before then answered items regarding prevention of HIV/AIDS. An average of only 15% of respondents throughout all five communities indicated that abstaining from sex avoids HIV/AIDS, with zero respondents from Choquette indicating this. However, an average of 55% of respondents throughout all five communities indicated that limiting sex and staying faithful to one partner avoids HIV/AIDS, with 92% of respondents from Choquette indicating this. Twenty percent of respondents identified condoms as a method to prevent HIV/AIDS. Fourteen percent of all respondents throughout the five communities indicated that they did not know what can be used to prevent HIV/AIDS.

Figure 25



10. Hand-Washing Practices

All women given the survey responded to the one item regarding hand-washing practices. Averages of 6% of all respondents never wash their hands with soap. This ranges from 1% in Rousseau to 12% in Laferme. The most common time of hand washing throughout all five communities is after defecation with 81% of all respondents washing their hands after defecation. Ninety percent of respondents from Laferme wash their hands after defecation, and only 70% in Roche Jabouin do the same. Figure 26 displays the percent of respondents that never wash their hands with soap and the percent of respondents that wash their hands with soap

only after defecation, throughout all five communities. Table 9 summarizes all responses to the hand-washing item on the survey.

Figure 26

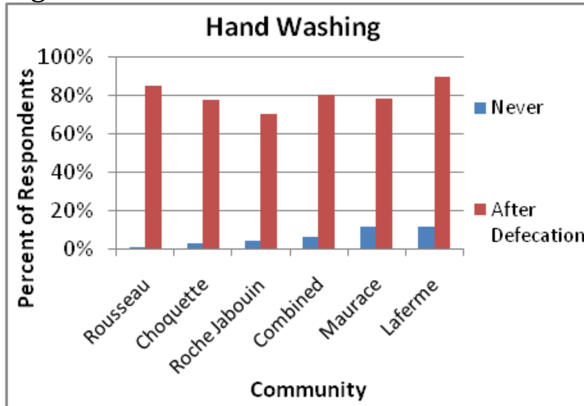


Table 9 Percentage of Respondents who Wash Hands with Soap in the Identified Settings

Setting	Choquette	Rousseau	Maurace	LaFerme	R. Jabouin	**Total**
Before preparing food	92.2	83.9	19.1	30.8	84.5	**61**
Before feeding children	3.9	2.3	58.4	7.7	54.9	**25.4**
After defecation	77.9	85.1	78.7	89.7	70.4	**80.6**
After attending to a child who has defecated	3.9	3.5	19.1	0	11.3	**7.7**
Never	2.6	1.2	11.2	11.5	4.2	**6.2**

11. Water Quality and Hygiene

The most common main source of drinking water throughout all five communities is surface water from a river. Figure 27 shows the percent of respondents from each of the five communities using surface water as their main source of drinking water. Seventy-one percent of all respondents throughout all five communities indicated that their water comes from surface water. Zero respondents from all communities indicated that their main source of drinking water comes from piped water into the house or collected rain water. Rousseau is the only community where any respondent(n=1) indicated that their main source of drinking water is bottled water. Respondents were then asked if their water is treated to make it safer. The results are shown in Figure 28. Throughout all five communities, 22% of respondents indicated that they do treat their water to make it safer. This ranges from 56% of respondents in Choquette to 10% of respondents in Laferme. Respondents who

indicated that they do treat their water to make it safer were asked the method in which they treat their water to make it safe to drink. Ninety-four percent of respondents throughout all five communities who treat their water use bleach or chlorine, added to a water cloth, to make it safer to drink. One-hundred percent of respondents from Maurace, Laferme, and Roche Jabouin who treat their water use bleach or chlorine added to a water cloth. Zero of the respondents throughout all five communities who treat their water use a filter to make it safer.

Figure 27

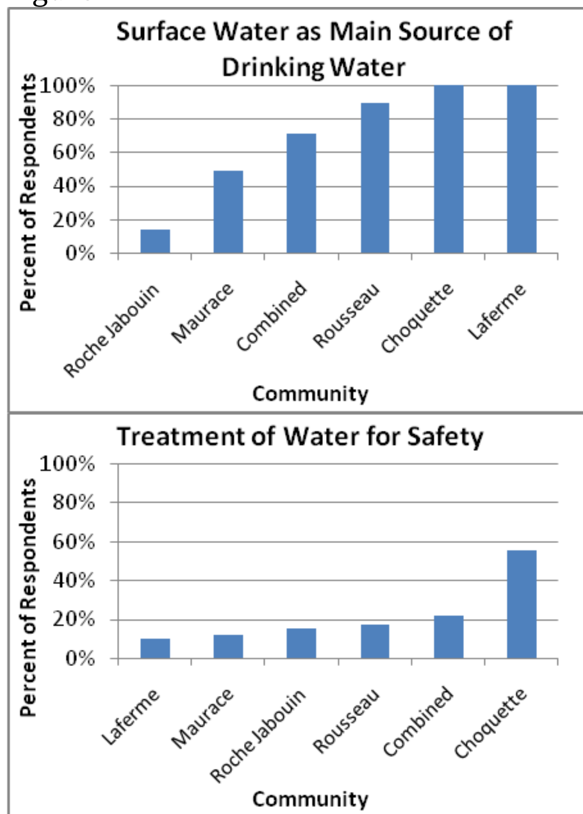
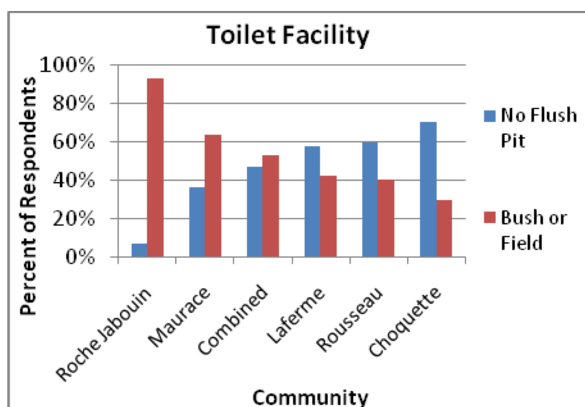


Figure 28

All respondents to the field survey tool were able to respond to one item regarding their type toilet facility that their household uses. The two most common toilet facility types throughout the five communities are a pit toilet with no flushing water and a bush or field, with 47% of respondents indicating that they use the former, and 53% of respondents indicating the latter. This is displayed in Figure 29. Zero respondents from all five communities indicated the use of a flush toilet to a septic tank or sewer, or a pour flush toilet to a pit. Ninety-three percent of respondents from Roche Jabouin indicated that they use a bush or field as their toilet facility.

Figure 29



12. Diet Screening

All survey respondents were asked to list the foods that their family ate in the last three days. A quality of diet score was then calculated by determining the number of food groups present in each diet for the past three days, with a 1 meaning poor nutritional quality made of all carbohydrate and 4 meaning excellent nutritional quality with all food groups represented. The average diet quality score was 2.1. Table 10 lists the diet score and most commonly eaten foods of each locality.

Table 10: Diet Screening Results by Locality

Locality	Diet Score	Most Commonly Eaten Foods
Choquette	2.2	Spaghetti, soup, breadfruit, rice
Rousseau	1.7	Breadfruit, bread, rice
Maurace	2.4	Plantain, cornmeal, millet, beans
LaFerme	2.1	Rice, beans, breadfruit, plantain
Roche Jabouin	2.1	Rice, breadfruit, manioc, beans

13. Socioeconomic Position/Social Capital

All respondents to the survey were given the opportunity to respond to four items pertaining to amount of education, occupations, and social networks. Across all five communities, 49% of respondents have no education. Twelve percent of respondents from all communities have more than a secondary school (high school) education. This ranges from 0% in Laferme to 38% (N=29) in Choquette, displayed in Figure 30. Table 11 summarizes the results of the education level item. Roche Jabouin has the highest rate of the respondents' husbands' being skilled teachers or managers compared to all the other communities, at 4%. Maurace and Laferme both have zero respondents' husbands' working as skilled teachers or managers. As shown in Figure 31, the majority of the respondents' husbands' occupation is subsistence farming laborer. This ranges from 97% in Maurace to 70% in Laferme.

Laferme has the highest rate of unemployment among respondents' husbands at 10%. Zero respondents' husbands in Choquette are unemployed.

Table 11 Education Level of Respondents by Percentage

	No Education	Unfinished Primary School	Finished Primary School	Unfinished Secondary School	Finished Secondary School (or more)
Choquette	22	3	38	0	38
Rousseau	50.6	1.2	33.3	0	14.9
Maurace	69.7	28.1	1.1	0	1.1
LaFerme	53.9	30.8	5.1	10.3	0
Roche Jabouin	47.1	15.7	24.3	5.7	7.1
Total	49.4	15.6	20	3	12

Figure 30

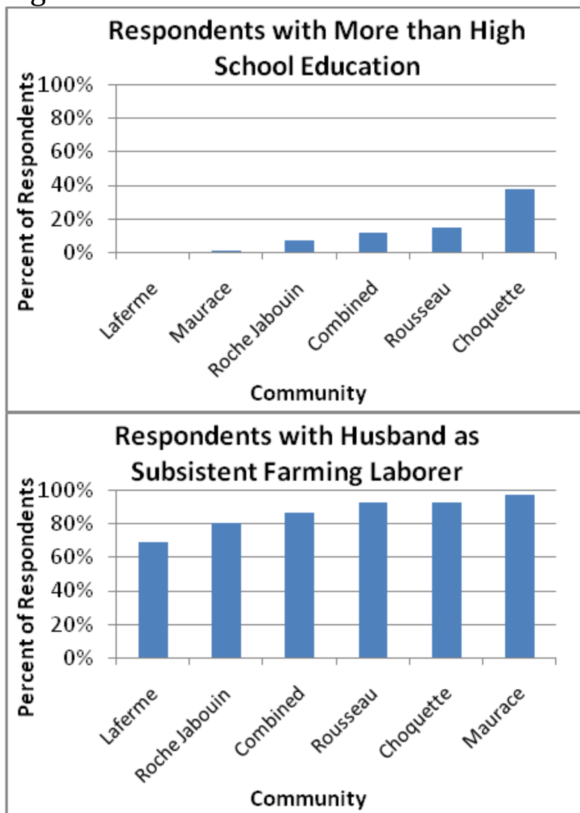


Figure 31

Few respondents are currently receiving, or have in the past received, money from family members who are working in the United States. Roche Jabouin has the highest rate of receiving money from family in the United States in both the past (14%) and present (12%). Choquette has the lowest rate of respondents receiving

money from family in the United States at 3% for both past and present. This is shown in Figure 32.

Respondents from Rousseau networked the most in the last month, with 52% indicating they attended 8-10 group activities in that time period. Zero respondents from both Choquette and Roche Jabouin indicated that they attended 8-10 group activities in that time period, or 5-7 group activities. Figure 33 displays that overall, 40% of respondents from all five communities attended between 1 and 2 group activities within the last month. Table 12 illustrates the amount of participation in group meetings by each of the localities, and Table 13 lists the groups most frequently attended by respondents from each locality.

Figure 32

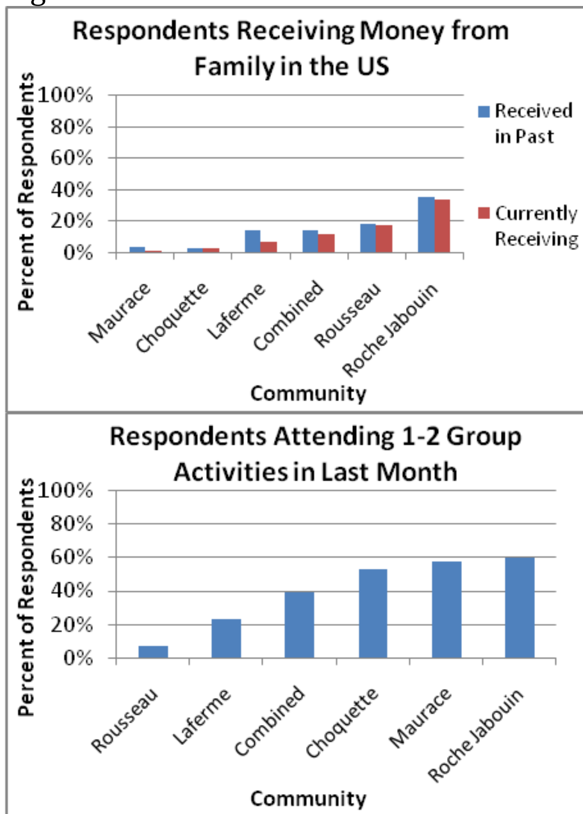


Figure 33

Table 12 Amount of Participation In Group Meetings per Month, by Percentage

	0 Group Activities	1-2 Group Activities	3-4 Group Activities	5-7 Group Activities	8-10 Group Activities
Choquette	42	53	5	0	0
Rousseau	35.6	6.9	4.6	1.2	51.7
Maurace	12.4	57.3	24.7	4.5	1.1
LaFerme	35.1	23.4	35.1	2.6	3.9
Roche Jabouin	32.9	60	7.1	0	0

Total	31	39.5	15.5	1.8	12.3

Table 13 Group Meetings Most Commonly Attended by Locality

Choquette	Women's group; church; MOIAD; ODSOC
Rousseau	Church; group "tetansanm de rousseau"
Maurace	Church; group mityel
LaFerme	Church: women's group; group mityel, health group
Roche Jabouin	Church; women's group; community group

14. Mental Health

All respondents to the survey were asked about two depression screening items taken from the PHQ-9, an evidence based depression screening tool used in the U.S. and multiple other countries. Forty-five percent of respondents throughout all five communities reported being bothered by little interest or pleasure in doing things for several days in the last two weeks. Respondents from Maurace have an 82% rate of being bothered by this for several days in the last two weeks. Forty-seven percent of all respondents throughout all five communities reported being bothered by little interest or pleasure in doing things nearly every day. This ranges from 15% in Maurace to 81% in Choquette. Also, the majority of respondents (just over 50%) reported having been bothered nearly every day by feeling down, depressed or hopeless. This ranges from 22% in Maurace to 81% in Choquette. The results are summarized in Tables 14 and 15.

Table 14 Percentage of Respondents who Bothered by Little Interest or Pleasure in Doing Things

	Not at all bothered	**Bothered several days**	**Bothered more than half of days**	**Bothered nearly every day**
Choquette	1.3	18.2	0	80.5
Rousseau	2.3	26.4	6.9	64.4
Maurace	0	81.8	3.4	14.8
LaFerme	12.8	44.9	1.3	41.0
Roche Jabouin	13.0	52.2	1.5	33.3
Total	5.5	45.1	2.8	46.6

Table 15 Percentage of Respondents who Bothered by Feeling Down, Depressed, or Hopeless

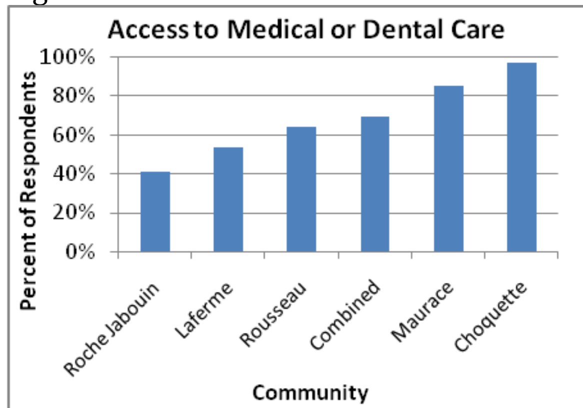
	Not at all bothered	**Bothered several days**	**Bothered more than half of days**	**Bothered nearly every day**
Choquette	1.3	18.2	0	80.5
Rousseau	2.3	27.6	6.9	63.2
Maurace	0	76.1	2.3	21.6

LaFerme	15.4	35.9	2.6	46.2
Roche Jabouin	11.6	44.9	2.9	50.6
Total	5.8	41.1	3	50.1

15. Access to Care

In the last twelve months, 69% of respondents were unable to access medical or dental that they believed necessary, ranging from 40% in Roche Jabouin to 97% in Choquette, as shown in Figure 34. Overall 92% of respondents, and 100% of respondents from Choquette, reported the reason they were unable to access care was a lack of money. Fifty-seven percent of those unable to access care from Roche Jabouin say it was because it was too far to travel. Other infrequent reasons given for not being able to access care were that no one could help and no medical person was available when the respondent went to the clinic or hospital.

Figure 34



16. Health Status

The final survey topic regards health status and the opinion of the respondents on their own health status. Zero respondents from all of the communities deem their health status to be excellent. Ninety percent of respondents believe their health status to be poor, with 97% from Choquette believing their health status to be poor. This is shown in Figure 35 and summarized in Table 16.

Figure 35

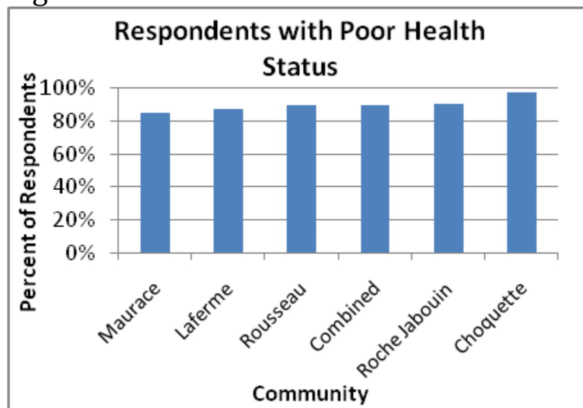


Table 16 Respondents Perception of their own Health Status by Percentage

	Excellent	**Very Good**	**Good**	**Fair**	**Poor**
Choquette	0	1	1	0	97
Rousseau	0	3.5	0	6.9	89.7
Maurace	0	1.1	12.5	1.1	85.2
LaFerme	0	1.3	0	11.5	87.2
Roche Jabouin	0	1.4	2.9	5.7	90
Total	**0**	**1.8**	**3.5**	**5**	**89.8**

17. Socioeconomic Status

A socioeconomic status indicator was calculated for each of the households surveyed. This was constructed based on a standardized assessment of: number of rooms in a house, material out of which walls were made, material out of which the floor was made, number of appliances in the house, quality of air ventilation, condition of the yard, variety of fruit and vegetables in gardens, and variety of livestock owned. This was scored on a 0-5 scale. There was very little variation around the average of a score of 3 across the five localities, including: Choquette: 3.25; Rousseau: 2.89; Maurace: 2.88; Laferme: 2.92; Roche Jabouin: 3.09.

In addition, the percentage of households that own gardens distant from the property where their home is build was assessed and exhibits variation between localities. Overall, 47.5% of households have gardens distant to their home property, with a range from 11.3% in Roche Jabouin to 93.3% in Maurace. This is illustrated in Table 17.

Table 17: Percentage of Households with Gardens Distant from Property by Locality

Choquette	49.4
Rousseau	29.9

Maurace	93.3
LaFerme	46.2
Roche Jabouin	11.3
Combined	47.5

Discussion and Conclusion

There are several limitations to a survey such as this. First, the sample size of children, and therefore the results of the first eight topic areas of the survey, is small and diminishes the statistical power of the results. Second, though standardized training took place and supervision was maintained throughout the survey process, some variation in the way the questions were asked may have taken place by locality, attributing to some of the difference noted between villages. Finally, respondents themselves were necessarily allowed to decline to answer and were informed of the purpose of the survey, which may have created a participatory bias.

In spite of these limitations, the sample method was sound and the sample population large enough to provide useful information about these five localities for the purpose of designing a public health outreach program to target the health needs of these specific communities. The most valuable lessons learned include:

- Improving immunization rates among children under 5 is identified as an important need in these five localities. For each of the given vaccinations, approximately half (ranging from 37.6-64.7%) of children have received them. More importantly, only 11.5% of children in all five localities, ranging from 6.7% in Choquette to 14.7% in Rousseau, have a vaccination status that can be considered "up to date" and timely based on the World Health Organization recommended vaccine schedule for Haiti. **Clearly, No Time for Poverty can play a significant role in improving vaccination rates and protecting the health of the children in these five localities.**

- **Overall, one quarter (26.7%) of the children in the selected localities below the normal limits of weight for age, indicating some degree of growth retardation and malnutrition.** Of these, 15% are categorized as moderately malnourished, and 11.7% are severely malnourished. The variation between localities in this area is also important. Maurace has the greatest percentage of children outside of normal limits (52.6) and Roche Jabouin has the least (16.7). In addition, Choquette has the greatest number of those classified as extremely malnourished (18.7). Improving child health in this catchment area will necessarily involve improving the nutritional status of the community, particularly those children identified as most vulnerable. **Determining what has created the difference between communities may also yield information that is useful for designing educational programs and interventions** (for example, by identifying

what mothers in Roche Jabouin do to prevent extreme malnutrition, a curriculum can be designed that is already proven to be culturally appropriate and effective for mothers in the region).

- Most women seek prenatal care (approximately 80%), though they appear to do so only later in their pregnancy. **The provision of prenatal care therefore represents an important way for a new clinic to provide a needed service to the population. Also, education and incentives that encourage women to receive prenatal care as early as their first trimester of pregnancy would improve maternal and infant health outcomes.**

- **The majority of women (approximately 80%) give birth with the help of auxiliary midwives.** These midwives represent important potential collaborators for a public health outreach program, both to provide training to improve their capability and to partner with for the sake of educating and reaching pregnant women within the communities. Also of note, the number of nurse midwives is high in Choquette, while the number of traditional birth attendants is high in Roche Jabouin.

- The knowledge, practices, and attitudes surrounding breastfeeding shown by this survey indicate that a focus in this area could have a major impact on the health of children. **Though the vast majority of women breastfeed, very few in any of the localities practice breastfeeding alone for the recommended six months following delivery.** Education and support to encourage more breastfeeding for longer periods of time and proper weaning of infants is hugely important in this population. In particular, women in Roche Jabouin are not taking advantage of the first colostrum of the breast by attempting to latch the infant within the first hour after birth.

- Women were largely able to identify some important indicators of illness in children, **but only 9% knew that fast or labored breathing is a sign of concern.** This indicates that education about signs, symptoms, and treatment of acute upper respiratory tract infections in children is essential in these localities. Also of significance is that the **mothers are largely the sole decision makers regarding the health care of their children,** and therefore they should be targeted for educational messages (though fathers clearly play a role; in addition, other evidence indicates that including fathers in health messaging for children improves health outcomes). Mothers already appear to be highly motivated to take their children to seek care while sick (86% indicated that they take their child to a hospital or clinic when sick, though cost is often prohibitive).

- The survey provides a picture of the health status of the children in each of the five localities. Overall, the point prevalence of illness in children is striking. Survey results indicate that, at any given time, 42.9% of the children have diarrhea, 55.6% have a cough indicative of an upper respiratory tract infection, and 52.6% have a fever. Children in Choquette and Maurace have even higher

percentages of these illnesses, which should elicit more specific attention. **As death due to dehydration secondary to diarrhea and pneumonia secondary to acute upper respiratory tract infections make up the majority of under-five mortality in Haiti, these results are sobering.** There is clearly a great deal of need for both prevention and treatment of these illnesses in these five communities.

- **Of particular importance is the cultural belief evident in the survey that children who are sick should be offered less to drink and less to eat:** 85% of mothers offered less to eat and 79% of mothers less to drink when their child was ill; only 4.8% of respondents offer sick children more to eat, and only 2.4% of respondents offer sick children more to drink. **This is an important area to target for education outreach in all localities.**

- Though the majority of respondents know that mosquitoes cause malaria, very few respondents were able to identify bed nets or draining water that has collected in the open as mechanisms of prevention. This represents an important area for increased public health education to prevent the spread of malaria during the rainy season.

- Though knowledge exists about family planning methods, there is significant room for improvement through education and possible provision of contraceptive methods to women in these localities. Of note, women in Choquette appear to be the best educated, particularly about condoms, and women in Rousseau and LaFerme the most in need of additional information about birth control methods. This is also reflected in the rates of birth control use: 76% of women in Choquette have used birth control at some point in the past, while only 6% in LaFerme. Because condoms appear to be the birth control method people are most familiar with and most commonly used in all localities but LaFerme, the mere provision of condoms, particularly along with education, could be very valuable as a component of public health outreach.

- **Overall familiarity with HIV/AIDS as a disease was high (90%), but respondents were not able to reliably or consistently describe risk factors or protective factors regarding the disease. This area represents an important component of education for the health of the communities.**

- Knowledge and practice of hand washing before preparing food and after defecation of respondents was high; however, only 25.4% of respondents wash hands before feeding children, and only 7.7% report washing hands after changing the diaper of a child who has defecated. Education on the important of these mechanisms to prevent the spread of childhood diarrheal diseases could therefore be very beneficial.

- The source and quality of water is very locality dependent. Respondents in Laferme, Choquette, and Rousseau predominantly have open river or spring water as their primary source, which is considered the least safe source for protection from waterborne disease. Maurace respondents are split between surface water and a closed pump, and the majority of respondents in Roche Jabouin get their water from a closed pump, which is likely to be a safer source. Of note, respondents in Choquette are far more likely to treat their water than those in any other location, and all who report treating their water do so with chlorinated bleach**. Improvement in water quality is an essential component of the health of any community. In the short term, utilization of the knowledge that chlorinated bleach is commonly used to treat water can help inform an education campaign that informs about how to do so in the safest manner and potential alternatives, such as boiling water. Encouraging mothers to give children with diarrhea treated water could also add value.**

- Proper sanitation is one of the most important components of community health, and the majority of respondents are lacking this component by using either the bush or field for defecation. The situation in Roche Jabouin is particularly concerning, as nearly 90% of respondents do not have a designated latrine or location for safe hygiene practices.

- Survey responses indicate that the diet of most of the inhabitants of all five localities, at least during the months of July and August when the survey was conducted, is very similar. Respondents in Rousseau have the lowest quality of diet, while respondents in Maurace have the highest quality. **All respondents could benefit from education about the importance of adding fruits and vegetables when possible and varying the carbohydrates and proteins used commonly in their diet.**

- In terms of socioeconomic position and capital, there is subtle variation in the amount of education received in each of the localities, with those in Choquette the most educated. Of note, nearly half of the women have had no education at all. Also important to be aware of is that there is almost no support that is coming in from family members abroad to respondents.

- The amount of community participation varies between communities and may represent the opportunity for success of health groups in these areas in the future. People in Rousseau are the most participatory, and those in Maurace and Laferme more so than those in Roche Jabouin or Choquette. Church is the most commonly attended social groups, indicated that collaboration with local church infrastructure may provide an important

avenue for connecting with localities and providing health information in the future.

- **The mental health results from this survey are striking. Nearly fifty percent of women in all five localities together exhibit signs of severe clinical depression based on their responses to standardized PHQ-9 questions. Though these results are preliminary and more information is needed to better assess the burden of depression, since studies indicate that women who are depressed also have children with poorer health outcomes. Perhaps more than any other area in the survey, these results deserve close attention and further exploration.**

- **Access to care in this region is significantly limited, and mostly by cost: nearly three fourths of respondents reported that they or a family member were unable to obtain care that was important, and over 90% of these indicated that the reason was that care was too expensive. In addition, people overall perceive their health to be very poor. This information strongly supports the need for provision of further affordable clinical services for inhabitants of these five localities.**

- There is no appreciable difference in the socioeconomic status of households within or between these five localities.

Overall, this information provides important baseline data for the status of the knowledge, attitudes, and practice regarding health in these five localities in the region of Port Salut, Haiti.