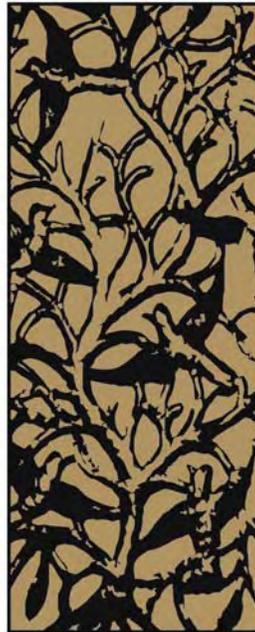


*Haiti
Health
Sector
Summit*

*Port-au-Prince
June 26 – 27, 2003*



SUMMIT PROCEEDINGS

Convened by:

**The U.S. Embassy/Haiti
and**

The U.S. Agency for International Development/Haiti

**June 26–27, 2003
Port-au-Prince, Haiti**



This report represents the proceedings of the June 26-27, 2003, Haiti Health Sector Summit, a conference sponsored by the U.S. Agency for International Development Mission to Haiti and the U.S. Embassy in Port-au-Prince.

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Acronyms

AOPS	Haitian Association of Private Health Care Organizations
ARI	acute respiratory infection
ARV	antiretroviral
AZT	Zidovudine
NVP	nevirapine
BWH	Brigham Women's Hospital
CDC	Centers for Disease Control and Prevention
CDS	Center for Development and Health
CMMB	Catholic Medical Mission Board
DOTS	Directly Observed Treatment Short Course
DSM	Department of Social Medicine at Harvard Medical School
FBO	faith-based organization
GHEKIO	Haitian Group for the Study of Kaposi Sarcoma and Opportunistic Infections
HAART	highly active antiretroviral therapy
HIV/AIDS	human immunodeficiency virus /acquired immune deficiency syndrome
HS 2004	Health Systems 2004 Project
IMCI	integrated management of childhood illness
LMM	Lumiere Medical Ministries
MOH	Ministry of Health (also MSPP)
MSH	Management Sciences for Health
MSPP	Ministère de la Santé Publique et de la Population (Ministry of Public Health and Population / also MOH)
NGO	nongovernmental organization
PAHO	Pan American Health Organization
PCIME	comprehensive management of childhood diseases
PIH	Partners in Health
PMS	minimum package of services
PMTCT	prevention of mother-to-child transmission
PVO	private voluntary organization
RH	reproductive health
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	The Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USC	unité communale santé (administrative health unit)
VCT	voluntary counseling and testing

Executive Summary

Haiti will celebrate 200 years of independence in January 2004. To commemorate the nation's upcoming bicentennial, the United States Embassy in Port-au-Prince and the U.S. Agency for International Development Mission to Haiti organized a two-day summit, June 26–27, 2003, on U.S. nongovernmental assistance in the Haiti health sector, in conjunction with the University of Miami and the Haitian Association of Private Health Care Organizations (AOPS). The summit's theme was to increase the amount, effectiveness, and impact of assistance provided to the Haitian health sector by individual U.S. citizens, private firms, and universities; and philanthropic, faith-based, nongovernmental, and Haitian Diaspora organizations.

More specifically, the organizers hoped the conference would:

- Strengthen collaboration among public and private sector organizations in planning and implementing activities aimed at achieving national public health objectives.
- Increase general knowledge and awareness of the size, scope, and coverage of U.S. nongovernmental health sector assistance activities in Haiti.
- Identify mechanisms to improve coordination and increase synergy among these programs and assistance activities of USAID.
- Increase contribution of these nongovernmental assistance activities toward achievement of key public health improvement goals and objectives in the sector.
- Continue progress in developing and/or expanding cooperative or "twinning" relationships between U.S. universities and service provider organizations and Haitian institutions that have similar missions and programs.

U.S. Ambassador to Haiti Brian Dean Curran officially opened the Haiti Health Sector Summit with a dinner reception at his residence on June 25, 2003, for an estimated 180 guests, representing more than 40 U.S.-based individual philanthropists and organizations, and Haitian Diaspora associations.

Following welcome remarks the next morning by Pamela Callen, Acting USAID Mission Director, Dr. Henri-Claude Voltaire, Minister of Public Health and Population, extolled the success of the public and private sector partnership currently at the base of health service delivery in Haiti. The minister committed himself and the Government of Haiti to continue efforts to strengthen the effectiveness of this partnership and its impact on improving the health and well-being of Haitian women and young children.

The summit program was replete with presentations and heartrending examples of program successes from faith-based consortia, such as the Parish Twinning Program, Lumiere Medical Ministries, Children's Medical Missions to Haiti, and Catholic Medical Missions Board. Institutional programs such as Harvard University/Zanmi la Sante, University of Miami/Hospital Justinien, and Project Hope/Ministry of Public Health and Population were also highlighted. Summit participants heard motivational addresses by Florida House of Representative Yolly Robinson, who was born in the remote Haitian village of Mirabalais, and Kimberly Green, president of the Green Family Foundation.

The program of productive technical presentations and break-out sessions yielded 11 recommendations for post-summit follow-up, including:

- Provide a report of the proceedings of this summit by electronic mailings, Web site download, and limited direct distribution by USAID.
- Prepare, update, and distribute a directory of U.S.-based organizations working in the Health sector in Haiti, including those attending the summit and all others that have been

- identified, along with a similar listing of indigenous Haitian nongovernmental organizations. This directory should be distributed along with the summit proceedings.
- Create a new or expand an existing Web site and establish linkages with other sites with similar missions, to facilitate coordination and exchange of information.
 - Provide a list of Web sites offering technical information and best-practice experiences for the priority public health programs discussed during the summit.
 - Establish a contact focal point and small support unit to assist in resolving problems for existing organizations and to facilitate the start-up and operation of new groups interested in starting activities in Haiti. The Haitian AOPS agreed to take on this role, with direct support to be provided by the Ministry of Health and USAID.
 - Prepare a detailed information package, including Web site and other contact information, on AOPS plans to facilitate the work of U.S.-based groups and organizations.
 - Support establishment of permanent nongovernmental organization coordinating bodies in each of the 11 Regional Departments and Administrative Coordinations. USAID is currently working with Management Sciences for Health, AOPS, and the Ministry of Health on this activity.
 - Encourage virtual and direct participation in the development of the New Five-Year (2003–2008) National Strategic Health Plan.
 - Provide similar participation in the preparation of detailed operational plans for an intensive campaign of activities to be organized fall 2003 to accelerate progress in meeting the public health priorities cited in remarks by Dr. Henri-Claude Voltaire, Minister of Public Health and Population.
 - Provide summit participants with the final plans for these programs to enable and encourage full participation.
 - Plan to organize follow-up national-level summits, at minimum of every two years, with the next meeting to be held in 2005.

Proceedings

Wednesday, June 25, 2003

I. Welcome Reception and Dinner Remarks

Brian Dean Curran

U.S. Ambassador to Haiti

U.S. Ambassador to Haiti Brian Dean Curran officially opened the Haiti Health Sector Summit on U.S. nongovernmental assistance providers by welcoming participants at his residence and discussing the impact of their assistance in Haiti. A portion of his remarks follows:

I am gratified to see representatives from such a large, diverse group of organizations, representing untold numbers of local community groups and participating institutions. This overwhelming manifestation of U.S. citizens, private firms, universities, philanthropic, faith-based, and other nongovernmental organizations, as well as the Haitian Diaspora I see here this evening, is ample testimony of your commitment to improving the health of Haitian women, young children, and their families.

Your tireless efforts have already had an enormous impact, contributing to significant improvements in the health status nationwide. These activities have ranged from contributions made by individual benefactors such as Dumas Simeus, whose long-held dream to bring the finest in high-quality modern health care services to the village of his birth has been realized with the recent opening of their new health clinic in Pont Sondé, to longstanding institutional relationships of more than 20 years' duration, like the Cornell University/GHESKIO and Harvard University/Zami la Santé programs in the area of HIV/AIDS.

Your efforts have been launched from all areas and regions of the United States, such as the Konbit Santé/Hospital Justinien program out of Portland, Maine, or the Saint Luke's Hospital/Hospital St. Croix collaboration out of Kansas City, Missouri.

They come in sizes large and small, as seen in the scores of medical missions organized annually by Lumiere Medical Ministries out of Gastonia, North Carolina, or the Parish Twinning Program out of Nashville, Tennessee, providing welcomed support to Hospital Bonne Fin and other health facilities and programs managed by the Mission Evangelique Baptist du Sud and other faith-based communities in Haiti.

Even with these valiant efforts, however, the health statistics in Haiti are sobering: One in 16 women has a risk of dying in childbirth; 80 of every 1,000 children born will never reach their first birthday; as much as 5 percent of the adult population is living with HIV/AIDS; and the number of orphans and vulnerable children in Haiti continues to grow. These statistics are by far the worst in the Western Hemisphere, and Haiti's proximity to the United States makes them even more disturbing and unacceptable.

During the next two days, we need to find more innovative ways to work together and, in collaboration, to increase the amount, the effectiveness, and especially, the impact of our assistance to the Haitian health sector. Working alone, we will not succeed. Our coordinated efforts have a much greater chance of success.

The U.S. Government continues to finance the largest program of donor assistance in the Haitian health sector. For 2003, we are providing more than \$20 million to support ongoing reproductive and maternal-and-child-health programs, and to dramatically scale up our HIV/AIDS and tuberculosis (TB) prevention and treatment efforts. The USAID-supported network of more than 30 NGO hospitals and clinics reaches approximately 2.6 million people, one-third of the Haitian population. USAID has also increased its support to the public sector, providing critical support for renovations, procurement of equipment and supplies, training, and personnel recruitment.

In addition, \$32 million in P.L. 480 Title II food resources this year is providing critical nutritional support to women and children, as well as funding for 139 maternal and child health centers, with almost a half million direct beneficiaries. Also, the U.S. Centers for Disease Control and Prevention, with a budget this year of more than \$2 million, is providing critical support to strengthen disease surveillance programs and laboratory capacity, and to purchase related commodities for the national program. Thus, this year alone, the U.S. Government is contributing approximately \$54 million to improve the health of Haitian citizens.

These programs are indeed having an impact. In the past decade, we have seen significant improvements in the health status of the Haitian population: a decrease in infant mortality from 110 to 80 per 1,000 children born; a decrease in chronic malnutrition from 32 to 23 percent; an increase from 68 to 79 percent of mothers receiving some kind of prenatal care; and a stabilization and decline of the HIV prevalence rate. But even with these impressive gains, the situation is still grave and much needs to be done.

Next year's bicentennial celebrations provide a unique platform and unprecedented opportunity. I am pleased to say that the Minister of Public Health and Population recognizes the enormous contribution of the U.S.-based organizations represented here tonight. We are both eager and committed to increase the effectiveness of this partnership to improve the health and well-being of the Haitian people. Together, we hope to draw on the long-held traditions of charitable contributions and community service by individual citizens and private groups such as yourselves, to build consensus around a limited number of key bicentennial objectives in the health sector, and to jointly develop plans for their achievement.

We will continue to seek new opportunities to expand cooperative or "twinning" relationships between our programs and like-minded U.S. universities and service provider organizations. Finally, drawing on these discussions, we will identify mechanisms to improve coordination and to increase synergies among your ongoing activities and our USAID and Centers for Disease Control and Prevention assistance programs.

Thursday, June 26, 2003

II. Opening Remarks

Pamela Callen

Acting Director, USAID/Haiti

As mistress of ceremony, USAID Director Pamela Callen, welcomed the summit participants, and introduced Haiti's Minister of Public Health and Population, Dr. Henri-Claude Voltaire. A portion of Ms. Callen's welcome remarks follows.

I am pleased to see so many individuals committed to improving the health of people of Haiti. The needs are great here, and no one person or group can address everything, but together in partnership, we can do great things.

We are fortunate. We are close to the United States, where we are less likely to be forgotten, more likely to attract attention, and more able to raise our case for development resources.

I have worked in many countries in which not much attention and not many resources were provided to health care. Global conflicts have turned many of our programs away from long-term development, toward addressing failed states, and trying to mitigate humanitarian disasters. Until now, we have not debated what our foreign assistance should be. It has been ten years since the fall of the Berlin Wall, which defined our last development strategy. I am aware that some of you stayed in countries in which U.S. leaders did not see fit to continue to invest development dollars, and you were left to face humanitarian disasters.

We are lucky to have the opportunity to make a substantial investment in Haiti. We are aware that some of you are here not just because we support you, but also because you bring your own resources and interests to work here. The future of Haiti—the future for Haitian children and mothers—is why we are all here. We are here to identify ways to increase collaboration and cooperation among our programs, to facilitate efforts by groups like yours, and to increase the effectiveness and impact of those programs to bring about genuine improvement in the health of Haitian citizens.

The challenge is to find a way to reach a common vision, and to move toward that vision. Let me offer an example. We put a man on the moon ten years from the day we said we were going to do so. Because we knew what we wanted, we were willing to invest the resources and we had a common vision. Why can't we work together here to address whatever differences we might have, and find a way to reach the goal if we put our minds to it? I encourage you to think innovatively. Look for new ways of doing business. Resolve your differences. We value your work, and we recognize the contributions that you make. We hope this meeting will further motivate you and encourage you to assist Haiti and its citizens, its human resources, and its valuable mothers and children who are Haiti's future.

III. Remarks by the Haitian Minister of Public Health and Population

Dr. Henri-Claude Voltaire

Dr. Voltaire welcomed participants and congratulated the U.S. Embassy, USAID, AOPS, and others for planning and organizing the summit. A portion of his remarks follows.

You belong to different institutions, universities, NGOs, churches, foundations, philanthropic organizations, and the Diaspora. I think that this diversity of our respective horizons should help us build a solid, complementary response to the problem of health in Haiti. Discussions will be centered on the HIV/AIDS epidemic, maternal health, child health, the prevention of mother-to-child transmission of HIV, essential obstetrical care, and public and private partnerships.

This country has been going through a political crisis for the past three years, with dire consequences for the health status of the population, and obviously, an aggravation of the suffering brought on by poverty. The indicators speak for themselves:

- The prevalence rate of HIV is estimated at 4.5 percent on the national level.
- The infant mortality rate is at 80 per 100 births.
- The maternal mortality rate is estimated at 500 for 100,000 live births.

Important efforts from the government and the private sector have been made to remedy this situation. The incomprehension generated by this crisis is a result of all kind of problems, which made us think about the strengths and weaknesses of our interventions, characterized by a lack of efficiency and effectiveness due, in part, to a lack of coordination.

I would like to refer to the inherent coordination function that lies with the Ministry of Health, which I have the honor to represent, and to invite you to identify the best ways to optimize the resources we have in this sector.

We are talking about a commitment for which we should strive and even advocate for in the development of common strategies and visions for interventions. In this way, during the course of this summit, I would like to recommend the development of a declaration of commitment articulated around five key points:

1. The health sector is considered a social and humanitarian, nonpolitical right. The right to health should be among the fundamental human rights—and observing this should be free from political considerations.
2. The leadership of the Ministry of Public Health and Population is indispensable in the sustainable development of health care in the country. The performance of the health system is closely linked to the existence of and to the respect for regulatory mechanisms. This regulatory role for the system is an exclusive privilege of the principal national authority, in this case, the Ministry of Public Health and Population.
3. The normalization of international cooperation in the health sector is critical for the consolidation of public/private partnerships. This public/private partnership strategy is certainly a conceptual model, but it is, above all, a model for concrete, complementary actions that will not happen in a country like ours with suspension of external aid to government institutions. The private sector alone cannot succeed. The public sector cannot. Complementary programs are indispensable.

4. The development of a National Plan for Health Sector Reform—for which the process will begin next week—is an opportunity to give the sector not only a common agenda, but also, above all, a common plan. In this reform of the sector, the Ministry has decided to follow a progressive approach, and with the participation of different players coming from different levels of the system.

This reform focuses on:

- decentralization through putting in place communal health units;
 - making the health services more professional;
 - making essential drugs available and accessible; and
 - ensuring that health financing is sustainable.
5. We will commemorate the bicentennial of our independence on January 1, 2004. This event is of the utmost importance, not only to the Haitian population, but also to the world, and must be organized through a specific program with the objectives to:
 - offer an equal survival chance to all children of Haiti through prioritization of integrated management of childhood illnesses and the eradication of diseases for which we have immunizations;
 - guarantee universal access to emergency obstetric care for all pregnant women through adequate health structures supported by a plan to strengthen the public referral system; that is, the hospitals; and
 - stabilize and control HIV/AIDS epidemic by making mother-to-child transmission a priority.

IV. NGOs' Contribution to Achievements of Haiti's National Health Objectives

Paul Auxila

Chief of Party, Health Systems 2004 Project, Management Sciences for Health

The following is an excerpt of Mr. Auxila's remarks.

This agenda is exciting. Let's take this unique opportunity to discuss and better understand Haiti's health needs and priorities, and the system's success and challenges. But most importantly, let's put our collective knowledge and experience to work to identify what we can do to build on the successes and address the challenges.

As a Haitian American, it is inspirational to me that both the public and private sectors have chosen the bicentennial of Haiti's independence as a symbolic turning point to reaffirm commitment to improve health status of the Haitian population, to renew efforts to implement and strengthen programs that address national health priorities, to reduce infant and child mortality, to reduce maternal mortality, to lower the fertility rate, and to reduce transmission and control infectious diseases, particularly tuberculosis and HIV.

Haiti is a challenging environment in which to work, with overwhelming health problems related to rapid population growth, poverty, poor diet, and infectious diseases that have proven difficult to overcome. Although the Ministry of Health, nongovernmental organizations, and international partners have made significant progress in several areas, the challenges continue, and much remains to be done. We must consolidate our achievements and continue our work together to

promote and support the further expansion of quality services, and to strengthen governments, health programs, and public and private partnerships.

Our task, not only as private partners, but also as stakeholders in this process, is to understand the problems and their underlying factors, to consolidate what has been done, and to effectively build on what exists.

The main purpose of these two days is to increase the amount, effectiveness, and impact of our assistance to the health sector. So we thought it would be useful to provide an overview of what is being done, particularly as it relates to U.S. assistance with the health sector through USAID and the contributions of NGOs in the achievement of Haiti's health objectives.

There is a long tradition of public/private collaboration and partnership in the Haitian health sector. Recognizing this, in 1982, the Ministry of Health (MOH) encouraged the creation of the Haitian Association of Private Health Care Organizations (AOPS). Subsequently, other NGOs were created. These institutions and many others focusing on service delivery have been extremely active partners with the MOH and its cooperating agencies in strategic planning, program design, training, service delivery, and operations research.

The NGO community is now vibrant. It works at the central and local levels, contributing to all aspects of the national health program, and providing slightly more than half of the health services being delivered today. During the past few years, Haitian NGOs, especially those supported by USAID, have been involved in interventions related to maternal and child health; family planning; nutrition; prevention and control of sexually transmitted infections, including HIV/AIDS and tuberculosis; and food security; as well as management interventions, such as pharmaceutical health commodities and logistics.

Maternal Health and Family Planning Beginning in 1996, Management Sciences for Health launched the USAID-funded Health Systems (HS) 2004 Project. In the past six years, the project has focused on strengthening the management and service delivery capacity of a group of NGOs to enable them to provide an integrated package of health services and to identify target populations in specific geographic areas. The services package includes child survival, as well as maternal health and family planning services, being provided in health facilities and through extensive community programs. This group of NGOs, known today as the HS 2004 Network, targets approximately one-third of the Haitian population, and is active in seven of the nine geographic departments.

The HS 2004 Network oversees 89 health facilities, including ten hospitals, 42 health centers, and 37 dispensaries. It uses the services of 129 doctors, 121 nurses, 394 auxiliary nurses, and more than 1,000 community health workers and 2,000 trained traditional birth attendants.

Last year's data show the results achieved by this group were significant. Full immunization coverage for children less than a year old averaged about 66.3 percent, and was up to 85 percent in some area. Almost a million children were weighed and participated in the growth-monitoring program. The prevalent use of modern family planning methods reached 25 percent, and 50 percent of pregnant women received prenatal care according to MOH norms. About 64 percent of pregnant women received delivery assistance by trained personnel, and 34 percent received postpartum surveillance at home. Nearly 38,000 ARI (acute respiratory infection) cases and 17,000 STI (sexually transmitted infection) cases were detected and managed.

In addition to the planning, monitoring, and performance-based interventions put in place, a key determinant of this impact is the network's conscious efforts to bring together relevant stakeholders and develop a common vision, to promote cross-fertilization, to share lessons learned, and to make local collaboration and partnerships stronger.

This collaboration and synergy have made quite a difference. In fact, the results in these areas have been three to four times superior to the results registered in other areas of the country.

Tuberculosis Program Another prime example of an effective public/private partnership—from program planning, implementation, and monitoring—is the national tuberculosis program. The goal of the program is to reduce morbidity, mortality, and transmission of tuberculosis, and to prevent the development of resistance. The MOH provides national leadership, policy, and normalcy frameworks, and ensures that program goals are achieved. At the departmental level, the MOH, in collaboration with private partners, develops departmental strategies and operational plans. The plans are then implemented under the ministry's leadership.

The program receives technical assistance and logistical support from two NGOs and CARE, a private voluntary organization. All three groups are funded by USAID. To date, this partnership has made possible the delivery of tuberculosis services, diagnosis, and treatment at more than 200 public and private service delivery points.

HIV/AIDS Program This year, the MOH plans to integrate quality voluntary counseling and testing (VCT) and prevention of mother-to-child-transmission (PMTCT) services in 27 departmental institutions (14 public and 13 private) with community information programs, and care and support programs for people living with HIV/AIDS. The implementation strategy is based on collaboration and partnership between the public and private sectors.

At the central level, the MOH's functions are to coordinate the work of donors; provide leadership and coordinate interventions; implement the strategy, policy, and legal framework; and coordinate VCT and PMTCT services. At the middle level, supporting NGOs are rehabilitating selected health infrastructures; providing clinical and management training for VCT and PMTCT teams and other staff; procuring pharmaceuticals and commodities; overseeing distribution and logistics; and implementing support for management tools and supervision systems. Most important are the service delivery points—both public and private—which provide VCT and PMTCT services; community programs for people living with HIV/AIDS; behavior change communication and community mobilization; and youth programs.

Food Security Another important program in service delivery is the P.L. 480 Title II Program. Its main objective is to reduce food insecurity in targeted populations. The program is implemented in specific geographic departments in collaboration with CARE, Catholic Relief Services, World Vision, and Save the Children Foundation. Interventions focus on maternal and child health and school feeding; providing a social safety net for the neediest; delivering food supplements to targeted institutions and HIV/AIDS-affected families; and supporting community-based efforts to improve agricultural productivity.

NGOs contribute not only service delivery, but they have also been active partners in areas such as training; program design and implementation; and monitoring and evaluation.

Pharmaceuticals and Commodities A main constraint limiting the impact of many priority programs is the unavailability of pharmaceuticals and commodities—even when they are available at the central level. In the past few months, Management Sciences for Health, working

with the Ministry of Health and its partners through the HS 2004 Network, started to develop a system to ensure the timely availability of essential pharmaceuticals and health commodities at both public and private sector delivery points. The system, to be launched later this year, aims to improve coordination between priority health programs, donors, distributors, and central and departmental service delivery points.

This is a big deal for us. Donors and programs can have a clear understanding of what is needed, when it is needed, and who exactly is committed to provide what and when. The idea is to ensure that all commodities go through a central pharmaceutical warehouse to ensure coordination and synergy. It is important that everything go through one system, eventually reaching the local level.

A main issue is lack of logistics and transportation to bring things from the central level to the local level. The idea of the system is to also serve as a catalyst to improve supervision and monitoring.

Planning and Coordination Last year, USAID, through its HS 2004 Project, launched a departmental strategy with the objective of improving the mechanisms to ensure better communication and coordination of private-sponsored efforts in the health sector in Haiti. The Management Sciences for Health team is currently working with the MOH, the National NGO Association, and concerned NGOs at the departmental level to identify and strengthen the capacity of a departmental coordination institution for each of the nine geographic departments.

These institutions, with HS 2004 assistance, will take a lead role in coordinating communication in program planning and implementation among all NGOs working in health or related sectors.

It is important to understand where we are, what some of the issues are, and what some of the constraints are, so that we can work together, build on what exists, and achieve better synergy.

The HS 2004 Network is achieving impressive results; however, what I present does not include the contributions of many of the NGOs, universities, and faith-based groups—many of which are represented at this summit.

There is no doubt that Haiti has limited resources, given the need and priorities, but as we review the many programs that you sponsor or represent, it is clear that we also have many opportunities. Given the health needs, constraints, and challenges that we all face, it will be only with increased communication, collaboration, and synergy that we will be able to effectively make a difference and have a sustained impact on the health status of the population we are here to serve. I invite you then to actively participate in these two days of discussions and to maintain an open mind—“think outside the box”—as we learn more about each other and together search for better mechanisms and strategies to build a brighter future for a population that deserves so much and has so little.

V. Epidemiological Situation and Response

A. Situational Analysis

*Dr. Eric Gaillard
The POLICY Project*

Dr. Gaillard provided a statistical overview of the health status in Haiti. The demographic highlights of his analysis follow.

The last published census in Haiti dates back to 1982. A new census was completed in January 2003, but the results have not been published yet. The data I present today are based on the 1982 census and the projections of The POLICY Project.

Demographic Indicators:

- Population in 2003: 8.4–8.9 million
- Births: 270,000 new births annually
- Fertility rate in 2002: 4.2 (The number of desired children is three, which means women have more children than they desire.)
- Infant mortality ratio: 97 per 1,000 live births
- Maternal mortality ratio: 600 per 100,000 live births
- Where women give birth in 2000: 80% of births took place in the home
- Maternal and neonatal program index: Haiti scored 46 out of the 49 countries evaluated, which mean Haiti is among the lowest ranked countries in terms of access to maternal and neonatal care in rural and urban areas, vaccination, voluntary counseling and testing, and women who have at least one child before age 20.

HIV/AIDS Projections in 2003:

- Prevalence rate: 5.7%
- Number of people living with HIV/AIDS: 275,000; 139,000 are women
- Number of new AIDS cases: 33,000
- Number of deaths (aged 15–49): 20,000

B. Prevention and Community Mobilization Activities

*Elsie Laurent
Johns Hopkins University Communication Partnership Project*

Ms. Laurent's presentation was delivered in French.

C. HIV/AIDS Scale-up and Restructuring of the Health Care Delivery System

Dr. Marie Marcelle Deschamps

Secretary General, The Centers GHESKIO (The Haitian Group for the Study of Kaposi Sarcoma and Opportunistic Infections)

A portion of Ms. Deschamps' presentation follows.

HIV/AIDS Indicators More than 230,000 Haitians, aged 15–49, are living with AIDS; 50 percent are women and more than 10,000 children under age 15 are infected. An estimated 146,000 children have lost their mother or both parents to AIDS. In 2001, an estimated 31,000 people died of AIDS, and 196,000 have died since the beginning of the epidemic. The infection rate among women seeking prenatal care is 4.5 percent, and it may be as high as 12 percent in some areas.

Socioeconomic Indicators Haiti is one of the poorest countries in the Western Hemisphere, with a growth rate of 1.4 percent. Life expectancy is 47 years for men and 51 years for women. The total fertility rate is 4.5, the infant mortality rate is 97 per 1,000 live births, and the maternal mortality rate is 600 per 100,000 live births. The adult literacy rate is 50 percent.

Fighting HIV/AIDS To address the HIV/AIDS epidemic, the Ministry of Health is working with the private sector, nongovernmental organizations, several international donor agencies (USAID, UNFPA, UNICEF, UNAIDS), and the Global Fund. Haiti's national strategic plan to fight HIV/AIDS for the 2002–2006 period focuses on reducing the population's risk of infection and decreasing the impact of the epidemic.

The GHESKIO Strategy GHESKIO is a private, nongovernmental organization. In collaboration with the Ministry of Public Health and Population (MSPP), GHESKIO helped develop an integrated HIV care and prevention strategy. The strategy is to develop voluntary counseling and testing centers and to integrate services for sexually transmitted infections, HIV, tuberculosis, and family planning into the existing departmental infrastructure. Integrated services include pretest counseling for HIV, syphilis, and tuberculosis; posttest counseling; and a minimum package of services for those infected with HIV. Integrated services also include reproductive health, family planning, prenatal care, and mother-to-child transmission prevention.

The goal is to expand GHESKIO's integrated care and prevention services to a national level. The objective is to create a public-private network of 25 sites to provide integrated HIV care and prevention services to 250,000 people vulnerable to HIV infection, communicable diseases, and other reproductive health problems; and maintain intensive activity monitoring, including sentinel HIV seroprevalence studies and longitudinal follow-up of children born to HIV-infected mothers. In the next five years, GHESKIO intends to test 250,000 people, and to identify at least 50,000 people with HIV infection, and 10,000 of their partners.

The GHESKIO strategy targets 12 private and 13 public centers (two or more in each of Haiti's nine departments) in which to reinforce human and material resources; provide training, supervision, and monitoring; conduct annual seroprevalence surveys; and encourage community involvement of people living with HIV/AIDS. Two sites already offer highly active antiretroviral therapy.

The expected outcome includes expansion of integrated HIV care and prevention services to 25 departmental sites, reinforcement of public-private sector partnership, and improvement of

services, laboratory backup, and data management. GHESKIO will rehabilitate or construct 11 new units in hospitals; provide laboratory equipment and a cold room and medication storage facilities; and distribute reagents, test kits, and other supplies. GHESKIO has also recruited and trained 39 medical personnel in 13 public centers.

Beneficiaries include medical and paramedical personnel; youth and adults of reproductive age; pregnant women and their families; HIV-infected individuals and their families; patients with TB and their families; patients with sexually transmitted diseases and their partners; victims of rape; and personnel exposed to contaminated specimens.

GHESKIO will examine indicators at years one through five to measure activities and services. Voluntary counseling and testing centers and mother-to-child transmission prevention programs will be integrated. Testing and care will be provided to all identified HIV-infected women to reduce the maternal transmission of HIV to the child. The goal is to decrease the national HIV seroprevalence by 3 percent in 2008.

D. U.S. Government Assistance in the Sector

*Carl Abdou Rahmaan,
Chief, USAID/Haiti Population, Health, Nutrition, and Education Office*

The following is an excerpt of Mr. Rahmaan's remarks.

Many of you have been torn to see the recent emphasis on HIV/AIDS, and you may be a little nonplused by seeing the continued need in other health issues and seeing the mega resources going toward HIV/AIDS, while still having problems vaccinating children and delivering a \$10 tuberculosis drug.

USAID programs are driven by a strategic objective planning process. Two years ago, USAID conducted a thorough review of that process and made some changes to it. We settled on three principal intermediate results: To continue the focus on the core elements of improving the quality and use of modern child survival and child health interventions; to strengthen the quality of reproductive health services, including maternal care; and to scale up our programming to reduce selected infectious diseases, primarily HIV/AIDS and tuberculosis.

Each area contains a matrix of activities: prevention, expansion of coverage and reach, and strengthening clinical areas. In child health, our focus is nutrition. In reproductive health, our focus is the need for clinical-based and referral services for long-term family planning methods and improved obstetric and delivery care. For infectious diseases, we need to expand our tuberculosis activities. These programs will be driven by the following specific objectives:

- Reduce infant mortality.
- Reduce maternal mortality. We are pleased with our attempts to reduce mother-to-child transmission of HIV/AIDS. Resources will be used to strengthen the program, build capacity, and augment the obstetric care component of the program.
- Reduce malnutrition in children under age 5.
- Reduce transmission of HIV/AIDS. Because Haiti is a target country in the President's Emergency Plan for AIDS Relief, we will be able to provide more support to our governmental and private sector partners. We will reach out to your organizations to strengthen community organization and community care and support activities.
- Reduce population growth.

Resource Levels The U.S. Government is the lead donor in Haiti. Resources for direct health care amount to about \$20 million per year, and \$20 to \$25 million per year for food aid commodities. In the past few years, resources for HIV/AIDS activities have risen.

Principal Partners

Ministry of Public Health and Population USAID has a solid, effective partnership. We recognize that addressing Haiti's public health needs requires a tandem effort. USAID has a strategic objective agreement with the ministry to provide central-level technical and management support, and operational support to the nine regional departments and the two administrative directions for metropolitan Port-au-Prince and Nippes.

NGO Partner Organizations Management Sciences for Health implements the HS 2004 Project, a project that provides technical assistance to a network of 31 partner organizations that, in turn, provide a minimum package of services in tuberculosis control; HIV/AIDS prevention, care, and support; and national and departmental management and planning. Other NGO partners include the private health care organizations association (AOPS) and other local health service organizations.

USAID Worldwide Contractor and Cooperating Sponsors Family Health International is our lead technical partner in HIV/AIDS support. Management Sciences for Health helps manage the expensive technical components of delivering antiretroviral therapy for HIV treatment. Johns Hopkins University offers clinical services in maternal and reproductive health, and training and capacity development. The Academy for Educational Development works on nutrition for HIV/AIDS patients, antiretroviral therapy, and maternal nutrition to prevent HIV transmission to infants. The Futures Group offers assistance in strategy development, norms, and standards. Population Services International works in condom social marketing, prevention of mother-to-child transmission, general awareness, and responsible sexual behavior. John Snow Inc. and the Royal Netherlands Tuberculosis Association are principal technical backstops for the tuberculosis prevention program.

P.L. 480 Title II cooperating organizations, including CARE International, Catholic Relief Services, World Vision, and Save the Children, are active in six departments. They work with the Ministry of Health and with other NGOs. About 60 percent of their resources are for projects in maternal and child health, nutrition, Food for Education, agriculture, economic and environmental development, microcredit, social safety net support, orphanages, people living with HIV, and building capacity for local counterparts.

What Do We Support?

Policy Development and Program Planning We have become the full-service partner at the national and departmental levels in developing standards, services, logistics, and human capacity.

HIV Prevention Efforts At this stage of programming in Haiti, direct interpersonal communication, and increasing the amount and intensity of prevention efforts are the next step. We need to promote more peer counseling and more faith-based counseling to help people move toward their own prevention efforts.

Treatment Services We provide support for voluntary counseling and testing, infection case management, prevention of sexually transmitted infections, emergencies, mother-to-child

transmission, and postabortion care. We support the continuum of first-contact through care and support services. The facilities we support make their services available to more than 2.5 million people, or about a third of the Haitian population, who rely on our support for their primary health care services. USAID provides support to the national TB program in all 11 departments.

Community Care and Support Our renewed interest in community care and support stems from the health system's desire to return responsibility for these activities to the community. We will need to put in place the structures, systems, and networks to accomplish this goal. The resources required to do this are beyond the means of the government, and they are beyond the means of your organizations. We will intensify the notion of community action. We must use systematic and intelligent ways to identify the resources these communities need to make them more effective.

VI. Faith-Based Response

A. Parish Twinning Program of the Americas

Theresa Patterson
Director

A portion of Ms. Patterson's remarks follows.

The Parish Twinning Program began 25 years ago when we connected one church in Nashville, Tennessee, with a community in northwest Haiti. Now we have 340 twinings throughout the United States, primarily through the Catholic Church. Ninety-five percent are parish-to-parish connections; the remaining 5 percent are church-affiliated groups or organizations. In 1998, the program expanded, so that we now have 32 linkages in Cuba, Mexico, and elsewhere in Central and South America.

The Haiti program has 210 parishes and 38 projects; 82 have two or more linkages with the United States. The 340 twinings generate about \$2.5 million a year, all of which is used to fund a sister parish or project in Haiti. Most financial support is for education purposes; the rest is used for medical, pastoral, and economic purposes. Dr. Gil Irwin, in Manassas, Virginia, purchases medicines in bulk through his nonprofit organization and provides them to our teams for the cost of shipping only.

In 1989, Dr. Don La Font of Jackson, Tennessee, organized the first medical team. Since 1989, about 268 medical missions have treated more than 300,000 people, and 54 parishes now send medical teams to Haiti. We furnish medical teams with a medical mission resource notebook, which is a compilation of material used by different teams in preparing for their missions. Dr. La Font and others in the program provide orientation for groups that visit Haiti for the first time.

Although the Catholic parishes organize the medical teams, their services are ecumenical and include medical personnel from other cities and states. Each team averages 14 people, who submit their credentials to the local Catholic pastor in Haiti, who, in turn, presents them to the Director of Health for his sector. The Haitian pastor also provides accommodations for the teams and helps arrange their visit with the local clinic and community.

Some parishes and medical teams have also tried to promote better health care in their communities by providing funds to renovate or build a new clinic; pay salaries of Haitian doctors,

nurses, and other clinic personnel; educate a nurse or medical student; and furnish dispensaries with medicines and supplies.

In 1988, we began sending children and adults to the United States for surgery. To date, some 85 Haitians have been treated and sponsored by caring doctors, hospitals, parishes, and individuals. In the past five years, through a nonprofit organization called the Visitation Hospital Foundation, we have been working to build a full-service hospital in Petite Rivière de Nippes in southwest Haiti. We hope the facility will be both a teaching and training hospital for Haitian physicians and nurses so that some day, Haiti will no longer be dependent on outside health professionals.

Dr. Don La Font
Coordinator, Medical Mission Programs

The following is an excerpt of Dr. La Font's comments.

The Parish Twinning Program of the Americas held a national Medical Mission Conference in early June, in Indianapolis, Indiana. The purpose was to share experiences, network, and discern ways we could be more effective. Approximately 288 people representing 54 parish medical teams attended the conference. Presentations were made on such topics as common clinical diagnoses; ocular and dental care; hypertension and hyperthyroidism; and how to organize medical, dental, and surgical teams. Participants agreed to establish a central database to collect information from each medical team, particularly regarding the types of diseases encountered, the treatment regimens, and the number of patients treated.

Each medical mission consists of physicians, dentists, and allied health professionals. They work in clinics for about a week and consult with 1,200 to 1,500 people. Several eye teams have performed cataract surgery; optical teams have dispensed eyeglasses; dental teams have provided preventive care, restorative care, and extractions; and surgical teams have performed routine surgery.

Medical missions have affected health services in Haiti by: (1) treating those with acute infections such as malaria, scabies, and impetigo; (2) addressing malnutrition in the short term by providing protein supplements, such as powdered milk, peanut butter, and multivitamins; (3) managing chronic medical conditions, such as hypertension and acid reflux; and (4) managing trauma as it occurs. It has been difficult to carry out immunizations because of a lack of continuity, refrigeration, and documentation.

Medical missions provide services in poorly served areas, where usually only a small clinic exists; some send a small team to remote areas to set up a temporary clinic in a church, school, or outdoors. Teams frequently provide the transportation and money to treat a patient at the nearest hospital. For example, one team has an arrangement with Crudem at Milot and has paid during a five-year period an average \$150 each for 110 patients to have surgery. Arrangements are made for surgery in the United States if patients, such as those with major heart conditions, cannot be treated in Haiti.

Every medical team since 1989 has continued to send missions each succeeding year. Mission participants are witnesses to Haiti's poor health care for others in the United States, who, in turn, offer financial support for additional missions and clinics. Medical teams believe they are a source of hope to so many Haitians who feel they have been forgotten.

B. Catholic Medical Missions to Haiti

Kathryn Bolles
Director, Nutrition Program

An excerpt of Ms. Bolles' remarks follows.

Our goal is to reduce the level of malnutrition and associated infant mortality in children under age five. We have a staff of about 30 women who work as village supervisors. Our staff has developed good relationships with community leaders, health care workers, and mothers. The volunteers invite mothers into their homes to talk about child health and behavior change (e.g., health and family planning) issues. Mothers make a contribution, which varies from village to village and season to season. The volunteers serve a meal every day and explain how to prepare nutritious meals using a family's available resources. Many volunteers, staff, and mothers have graduated from the program; in some villages, up to 70 percent of the children have been "rehabilitated" from moderate to severe malnutrition to near-normal nutrition.

Some severely malnourished children have needed hospitalization. Albert Schweitzer Hospital staff members have trained us to use the World Health Organization protocols for treating severely malnourished children. For six months, one of our staff members has been in the hospital at all times, tracking the children who enter the pediatrics department, implementing the protocols, and following the children once they leave the hospital and return home.

We offer a microcredit opportunity for mothers of malnourished children who have graduated from our program. Once they learn the elements of child health care and meal planning, they have an opportunity to learn how to run a small business, and they become eligible to take out a small-business loan through a local aid bank. Our goal is to ensure that households have the resources they need to provide nutritious meals and better health care for their children.

We are just beginning a low-cost, safe drinking water project to address the issue of diarrhea in children, in partnership with the Centers for Disease Control and Prevention and with Population Services International. We work with families to assess the way water is stored and treated in the home, so that every time someone cooks with, drinks, or creates juice with water, clean water is used. The project emphasizes education, prevention, and care.

C. Lumiere Medical Ministries

Sharon Kolb
Staff Director

A portion of Ms. Kolb's remarks follows.

Lumiere Medical Ministries (LMM) has worked in Haiti since the 1930s, providing quality health care services. We are members of TECA, a network of 100 medical equipment and pharmaceutical suppliers for faith-based organizations. Part of the LMM mission is to work with Haitian doctors and nurses to promote better preventive health care practices and better patient care.

We work with a Haitian organization of 300 churches that implement services in community education, behavior change, family health, and treatment for sexually transmitted diseases. We also coordinate three health ministries.

Our community health program is largely funded by a USAID grant through Management Sciences for Health (MSH). We operate a community health center that started on a back porch and has since evolved into an emergency care center and a surgery center. We perform procedures that do not require a specialist. The surgical center now has an outpatient clinic that was built with the help of USAID funds. We collaborate with USAID and MSH to address HIV and sexually transmitted infections. It is challenging because we are a faith-based organization (FBO). We serve God, and we do not one day want to hear him say, “Wow, that program is really embarrassing.” A large challenge for FBOs like ours is to figure out how to coordinate and articulate our budget needs. We care about what we do. We go where people need us. It’s a challenge.

D. Catholic Medical Mission Board

John F. Galbraith
President and Chief Executive Officer

An excerpt of Mr. Galbraith’s remarks follows.

Affected by the distress of the leprosy victims in Haiti in 1913, Dr. Paluel Flagg went back to the United States, motivated others to make a commitment, and formed the Catholic Medical Mission Board (CMMB) in 1928. In 1989, CMMB received the Damian Dulton Award for outstanding work on leprosy in Haiti. In 2003, CMMB celebrates its 75th Anniversary of bringing health care to people in need worldwide, and begins the *Back to Haiti* Initiative.

The Haiti and CMMB Global Initiatives donate medicines and medical supplies, place health care volunteers (including doctors, nurses, dentists, and other allied health professionals), and provide training grants for building capacities of primary health care workers. In the past five years, CMMB has donated more than \$33.5 million in medicines and medical supplies to Haiti. This year’s donation of medicine to Haiti has totaled more than \$9.3 million.

Recipients of medicines and medical supplies in Haiti from CMMB include St. Damian’s Pediatric Hospital, Hospital Sacre Coeur in Milot, Haiti Parish Twinning programs, Partners in Health, Haitian Health Foundation, and Cross International

CMMB medical volunteers have been going to Haiti to serve since 1970. CMMB supplies volunteers to Hospital Sacre Coeur in Milot and St. Boniface Hospital in Fond des Blancs. Between 1970 and 1993, 406 volunteers served in Haiti. From 1994 to present, CMMB sent more than 1,000 short- and long-term volunteers to Haiti.

CMMB initiatives in Haiti include:

- Action For Family Health. Partners include CMMB, Pan American Health Organization (PAHO), Caritas, RISCAP, Ministry of Health, and others.
- Back to Haiti. In January 2003, CMMB launched this major public health initiative in Haiti with the Salesian Sisters of St. John Bosco, Catholic Church (Caritas and RISCAP), and St. Boniface Haiti Foundation.

- Salesian Sisters conducts an In the School Health Initiative, which will target 10,000 students, ages 5–18. The Salesian Sisters educational network will provide students with life-skills education for health, health care, and HIV/AIDS prevention.
- CMMB-PAHO Initiative, which covers IMCI (integrated management of childhood illness) and PMTCT. In-country, partners include the Ministry of Health and the Catholic Health Care Network (Caritas National, RISCAP, and Catholic Education and Radio Network).
- CMMB partners with Caritas National to scale up IMCI, implement PMTCT, and build capacities of church leadership for HIV/AIDS. (CMMB cosponsored the first National Catholic Conference on HIV/AIDS).
- PMTCT sites are at Hospital St. Boniface (Fond des Blancs), Hospital St. Jean (Limbe), Hospital du Sacre-Coeur (Milot), Hospital Alma Mater (Gonaives), Centre de Sante Rosalie Randue (Cite Soleil, PAP), and Hospital St. Francois de Sales (PAP).

VII. Operational Relationship Models

A. University and Other Institutional Twinning Programs

Dr. Arthur Fournier

University of Miami, Family Practice Residency Program/Haitian State University Hospital

A portion of Dr. Fournier’s remarks follows.

We started working in Haiti about nine years ago because there are people at the University of Miami—Haitian Americans and Americans—who care about this country. We started as a volunteer project. At that time, and to this day, we had a pitiful budget, but we have been fortunate enough to network and partner.

The Family Residency Training Program involves the University of Miami School of Medicine, Ministry of Health, Justinien Hospital, and the Hospital Bienfaisance de Pignon.

As we have heard about the programs presented by USAID and by the various organizations, I asked myself, “Where are all these people coming from?” It is clear that the long-term care for Haiti’s health has to come from Haitian people, and that involves training Haitian physicians for the realities of Haitian health.

We asked ourselves, “What can we do about Haitian health?” The thing we could do best is what we do well in Miami. My job in Miami is to link education to Miami’s underserved communities. Dr. Dodard, who is with me today, at that time, was director of Family Medicine Residency Training Program. We believed there was a huge need to train broad-based Haitian physicians as generalists for work in predominantly rural Haiti, which is where most of the people live. In the process of doing that—and I think this is a key point—there was an opportunity to deliver a large amount of service to poor people. An additional by-product of establishing an academic linkage outside of the capital in two hospitals in the northern part of the country is that, in the process, we were able to elevate the quality of services delivered for the entire hospital, not just the family medicine service.

University of Miami’s role has been to provide expertise in family medicine. We provide technical assistance to our Haitian partners and fiscal oversight. We have trained the Haitian

faculty, who now train the residents, and we provide the curriculum and periodic evaluation of the quality of the program.

The MOH's role is identifying the training of generalists as a national priority and accrediting the program. The ministry assists us in the recruitment of residents (the pipeline of getting doctors in). They provide us with the physical plant—the hospital, family practice center, and staff. They have a responsibility (this is a work in progress) with regard to taking over the program and ultimately the long-term responsibility of the program.

Hospital Cap-Haitien in Pignon provides our students with a rural health exposure. Until this program started, all medical students were educated in Port-au-Prince. The realities of rural health are different from the realities of Port-au-Prince. The hospital also provides a well organized community health program, to which our residents need to be exposed, and special expertise in surgical skills and community health.

We now have 7,000 patients enrolled in the Family Practice Center who are getting ongoing primary care. That generated 35,000 encounters in the past year. We have graduated our first class of five residents. All are working in underserved communities in Haiti. The medical training program also provides a platform to build in other health programs. For example, we hope to join the Twinning Project for reduction of MTCT this year.

We have only faced one problem, and that is sustaining the program. Through fund-raising, and blood, sweat, and tears, the program continues, but it is fragile. We hope that with time, we will reach sustainability, and the program will continue without our efforts.

Our second project, Medishare, is a partnership involving a charity we established, independent of the medical school, between the MOH, Zanmi la Sante, the community of Thomonde, and the Green Family Foundation. This is a wonderful project because the community of Thomonde approached us. We have worked with this community to bring it from no health care to episodic health care, to now continuing health care.

Through Project Medishare, we built a guesthouse, which is now the headquarters for our community health workers. We have renovated the dispensary, and now have a functioning clinic. We have provided an ambulance, which can connect the hospital in Cange with the clinic. We provide support for a full-time Haitian physician and 60 community health workers, thanks to the generosity of the Green Family Foundation.

The MOH gave us permission to use the clinic and provides us with a social service doctor, two nurses, and a laboratory technician. Zanmi la Sante trained our community health workers, provides special services (such as prenatal care), stocks the dispensary with all the medicines we need, and provides us with a place to send our difficult and challenging cases.

Dr. Serena Koenig
Harvard University/Partners in Health

An excerpt of Dr. Koenig's remarks follows.

Partners in Health (PIH) is a nonprofit organization within Harvard Medical School committed to providing a “preferential health care option for the poor” both globally and in the United States. PIH, a nongovernmental organization started 20 years ago, provides medical care to the poorest and the sickest. Major sites of operations include Haiti, Boston, Peru, and Russia.

- **Service:** Works with sister organizations, such as Zanmi La Sante in Haiti, to provide the highest possible level of health care to the poor.
- **Advocacy:** Works through major academic institutions, international organizations, and governmental offices to improve health care for the poor globally.
- **Research:** Institute for Health and Social Justice is investigating links between social and economic inequalities and poor health outcomes by linking scholarly analysis with community-based experience.
- **Training:** Trains physicians, nurses, community health workers, and other health care providers, both internationally, and in Boston.

Department of Social Medicine at Harvard Medical School (DSM) works in close cooperation with PIH on issues of community-based efforts to prevent and treat infectious diseases in developing countries. DSM closely links its research to ongoing service projects in Boston, Haiti, Peru, and Russia through:

- Research on the dynamics of infectious diseases of global importance. While the program has many ongoing research interests, it builds upon major research and service efforts designed to control tuberculosis (TB) and HIV.
- Training of students, residents, and post-doctoral fellows in infectious diseases.
- International training fellowships for front-line health workers and others actively delivering health care services at the community level.
- Faculty development for established scholars wishing to broaden their approach to epidemic and emerging diseases.

Brigham and Women's Hospital (BWH) is one of Harvard Medical School's major teaching hospitals. The hospital's Division of Social Medicine and Health Inequalities:

- Seeks to inaugurate innovative and multidisciplinary research in the arena of health disparities.
- Fosters, coordinates and leads efforts in training, research, and service to reduce disparities in disease burden and to improve treatment outcomes both in the United States and internationally.
- Works in close collaboration with DSM and PIH to improve the quality of health care provided to the world's poorest patients.

Introduction of HIV Prevention and Care in Central Haiti

- 1986: First case of HIV in Central Plateau
- 1988: Free serologic testing to diagnose HIV
- 1990: Intensified prevention efforts
- 1995: After it was demonstrated that AZT reduced mother-to-child transmission, PIH purchased AZT to provide it to all pregnant women. (More than 90 percent of women offered HIV testing accepted testing after AZT was made available free of charge.)

Use of Highly Active Antiretroviral Therapy (HAART) at Clinique Bon Sauveur

- 1996: HAART dramatically reduced morbidity and mortality in wealthy nations. PIH and DSM sought HAART for patients in Haiti, but they were refused by all donor agencies and drug companies.
- 1997: Medications were provided for post-exposure prophylaxis to victims of rape or professional injury.
- 1998: HAART was offered to a small number of patients with long-standing HIV disease who no longer responded to treatment of opportunistic infections.
- 1999–2003: PIH and DSM worked with other organizations to drop the price of brand-name drugs and to provide generic HAART regimens.

Directly Observed Treatment Short Course-Highly Active Antiretroviral Therapy (DOTS-HAART): Supervised Therapy for Advanced HIV Disease

- More than 3,500 HIV-positive patients are followed in the clinics.
- More than 400 patients are now being treated with directly observed HAART (DOTS-HAART).
- Each DOTS-HAART patient has an *accompagneur* (health aide).
- 86 percent of patients have suppressed viral loads.
- Less than 10 percent have required medication changes for minor side effects.

Initiation of Antiretrovirals (ARV)

If a patient is symptomatic or has a long duration of infection, a CD4 count is obtained. DOT-HAART is recommended for all patients with CD4 < 200 and for symptomatic patients with CD4 < 350. If there is co-infection with TB, HAART is deferred until TB treatment is complete. When necessary, two nucleosides are combined with dose-augmented efavirenz.

Scaling Up in the Central Department

Under the Global Fund proposal, we, along with the many partners, provide comprehensive HIV, TB, sexually transmitted infection, and prenatal care to the entire Central Department (population about 550,000). In addition, we will work to improve the primary health system. HIV is politically popular right now. People will pay for HIV programs, so we use HIV as a way to bring in money to improve the entire health system.

In Lascahobas last year, 20 patients a day were seen in the general health clinic; now we are seeing 250 patients per day. We used HIV money to build a hospital, pharmacy, and laboratory, and to provide electricity. Now in Lascahobas, we have a fully functioning public health clinic. In Thomonde, Dr. Fournier and his group are providing total health care, where two years ago there was absolutely nothing. In addition to Lascahobas, Boucan Carre, Belladere, and Thomonde, we will add six more sites during the next four years.

*Dr. J. Michael Taylor
Konbit Sante/Hospital Justinien*

The following is an excerpt of Dr. Taylor's remarks.

About three years ago, a group of community activists including physicians, nurses, business persons, attorneys, planners, and volunteers met in Portland, Maine, to discuss how we could be useful to help improve health care in a developing country. Most had some experience

volunteering outside United States, and most had frustrating experiences with short-term, episodic “medical tourism” visits.

We identified our strengths and weaknesses, our resources and deficits, and acknowledged that what the developing world most needed—sanitation, water, prevention, and health education—were not the areas of our expertise. Most of us were highly skilled professionals, and our resources were sophisticated—physicians, nurses, and hospitals. We did not want a rural clinic partner, nor did we intend to operate a health program from a long distance. We wanted to work with an established health care organization that we could help to make better. Our working mission statement became: “To develop and support—in collaboration with medical and nursing professionals and health administrators—an ethical, responsible, and sustainable health delivery system to meet the health needs of the community with maximum local direction and involvement.” Although this mission statement did not mandate us to collaborate with a governmental institution, the thrust of working in the “community with maximum local direction and involvement” kept our focus on public institutions.

The needs of Justinien Hospital seemed to fit our available resources. The hospital leadership and the Director of Health for the Northern District, then Dr. Myrtho Julien, welcomed us, and the presence of the University of Florida program in family medicine all came together to fit our program.

We have joined with the Justinien Hospital and the Ministry of Health for the Northern District, and are fully committed to giving what support we can for the foreseeable future. We have broadened our relationship by establishing a Sister Cities agreement between Portland, Maine, and Cap-Haitien, and by inducing the Roman Catholic Cathedral of the Immaculate Conception in Portland to partner with the Cathedral in Cap-Haitien. Nonmedical members of our organization are beginning to establish other business, religious, and educational relationships.

Thirty different volunteers have made 68 visits to Cap-Haitien in eight separate trips during the past two years. Working with hospital leaders to establish the priorities, we have tried to restore a functioning x-ray unit at the hospital. We have installed computers in the hospital and set up a satellite connection for Internet access so that the staff and residents can search for up-to-date medical information and communicate their needs. Medical professionals have developed partnership relationships for long-term support. We shipped a 40-foot container with 20 pallets of useful items that were determined in collaboration with the administration and professionals at the Justinien Hospital.

Some professional education has taken place. We have recruited a well-trained Haitian internist, Dr. Michel Pierre, to direct medical education for residents and medical students, and to work with us to identify how we can be most useful. Dr. Pierre will travel to Portland this summer to learn about the resources at the Maine Medical Center, a 600-bed teaching hospital.

What Are Our Next Steps?

We share with everyone a need for secure funding. We have found that public and private funding agencies finance targeted projects (e.g., HIV/AIDS), but they do not support infrastructure. We are determined not to be led by funding opportunities, but to hold to our principles.

We shall continue to upgrade medical equipment and to help make physical plant improvements. We hope to provide administrative consultations for the Justinien Hospital leadership. We plan to expand individual professional connections. We hope to start working outside the hospital with

the Ministry of Health to improve public health (e.g., in HIV/AIDS, prenatal care, family planning, tuberculosis). We will also nurture the Sister Cities relationships.

B. Private/Public Partnerships

*Dr. Sandra Laumark
Country Director, CARE International*

The following is a portion of Dr. Laumark's remarks.

CARE began working in Haiti in 1954. Today, CARE oversees an integrated development program with projects in HIV/AIDS, reproductive health, maternal-and-child health, education, food security, and water and sanitation. CARE/Haiti has activities in the Artbonite, Grand Anse, Northwest, and West Departments. CARE/Haiti works closely with local nongovernmental organizations, the Government of Haiti, private companies, and community organizations. Donors include the governments of Australia, Canada, Japan, and the United States; the European Union; United Nations agencies, private foundations, and individuals.

Representative Health Care Projects in Haiti

Reproductive Health 2001 Project The goal is to decrease sexually transmitted infections and reduce total fertility and maternal mortality rates by strengthening reproductive health services for women and adolescents in 35 rural health care facilities. CARE distributes information, education, and communication materials; and trains service providers and community health workers in family planning issues (e.g., modern contraception, maternal health, emergency obstetric services, HIV/AIDS).

Maternal and Children's Health Project The aim is to promote better health and nutrition through training and technical assistance for nurses in administrative health units (USC), and to promote better health and nutrition for the people who use USC services. The project targets 408,426 people.

Community-Based Care and Support to Families and Children Affected by AIDS The project aims to: reduce mother-to-child transmission of HIV; address the specific needs of HIV/AIDS-affected children; provide health services and socioeconomic support to people living with AIDS; and support organizations to provide care to AIDS-affected families. The project reaches 172,000 people in Baie de Henne, Bombardopolis, and Part-de Paix.

Care and Support Project for People Living with HIV/AIDS and Families CARE links offices of the Ministries of Health and Social Affairs with local volunteer groups to promote greater demand for voluntary counseling and testing services, treatment for opportunistic infections and psychosocial support for people living with HIV/AIDS, and better ways to address the care and support needs of children affected by HIV/AIDS. The project reaches approximately 171,000 people in nine localities.

Tuberculosis Project The objective is to improve TB diagnosis and treatment, and to reduce TB transmission. CARE has specialized teams that provide training and supervision skills for public and private health staff to develop annual TB-case detection plans; rehabilitate laboratories; reinforce the use of the directly observed treatment short course (DOTS) protocol;

improve logistics and stock management; and reinforce information, education, and communication activities.

Reproductive Health and Child Survival Project CARE works with local nongovernmental organizations and the Ministry of Health to promote integrated management of childhood illness protocols; promote immunizations for infants aged 12–23 months; treat respiratory infections and diarrhea; and improve infant and child nutrition. The project aims to ensure that health facilities provide quality reproductive health service; that women of reproductive age have access to family planning services; and that young people know about reproductive health issues and the risks of early pregnancy. The project encourages pregnant and lactating women to make prenatal and postnatal visits to health facilities, and promotes prompt treatment for sexually transmitted infections. The project supports 18 health institutions, 228 traditional birth attendants, and 42 local associations in Abricots, Anse d’Hainault, Bonbon, Chambellan, Corail, Irois, Jeremie, Moron, Pestel, and Roseaux communes, reaching 241,853 people.

Robert Northrup
Project Hope

Northrup discussed Project Hope, which is just starting in Haiti and represents a model for public/private partnership. An excerpt of Mr. Northrup’s presentation follows.

Project Hope is an international NGO; our annual budget is about \$100 million, about \$20 million of which represents program activities. We work in about 32 countries. In Haiti, we implemented a child survival project in partnership with Crudem at the Neilo Hospital between 1994 and 2001. A new child survival project in the Northeast Department began in earnest in December 2002, when we completed an initial agreement with the Center for Development and Health (CDS).

CDS was founded in 1974, initially to provide facility-based activities. CDS was best known for its activities in Cité Soleil until 1996. In 1989, CDS began to expand its activities to six communes in the eastern part of the Northeast Department. CDS manages the service delivery, whereas Ministry of Public Health and Population (MSPP) staff provide the health services. In 2002, CDS became a provider of technical assistance rather than a provider of services. The six communes have two community health units that serve about 100,000 people. The Northeast Department has nine Ministry of Health dispensaries and five private dispensaries. Many vacancies for nurses, auxiliary health personnel, and health promoters remain unfilled; the performance of the health care system is poor, and the infrastructure is decayed.

We used project funds to bring the MSPP staffing patterns up to the levels defined by MSPP, with extra auxiliaries, 81 promoters, and some community health unit supervisors. Our contract is very clear: It says what the Ministry of Health is going to do, what CDS is going to do, and what Project Hope is going to do.

We monitor to identify and solve performance problems, so that when we see something interfering with performance, we can take action to address it.

We aim to improve the management of fees collected at these facilities. We realize fees can be an important source of sustainability, and CDS has been able to collect 25 percent of the cost of the services from user fees. By the end of this project in four years, we aim to collect 15 percent of the cost of services through user fees.

Last, we aim to strengthen the community so that it can play an important role as this project continues beyond the end of the funding stage. To achieve sustainability, we will emphasize improved management and service quality because that is what is going to make people come for the service and pay user fees.

Higher fee recovery will cover additional auxiliaries; and health promoters will become entrepreneurs, practice community-based distribution, and begin to sell commodities such as oral rehydration salts, condoms, over-the-counter drugs, and so forth.

We recognize that we will be able to change the norms of some communities through mothers' clubs and the practice of different kinds of breastfeeding. These norms will, hopefully, persist beyond the time of the project.

In Haiti, we know that traditional birth attendants deliver 80 percent of the care. Village doctors care about the public, and they care about what they are doing. It is interesting that these practitioners freely provide all the drugs that supposedly are available only by prescription. In addition, they provide injections, but they may unknowingly be transmitting HIV because they do not have clean needles.

I have seen tremendously effective results in India and Pakistan, where we often worked with unlicensed, unregistered, untrained practitioners. We achieved high levels of IMCI performance from these practitioners, and we saw major changes in their behaviors. In Pakistan, we achieved a significant reduction in unsafe injection practices. We implemented a monitoring method called the verbal case review, which examines what practitioners are doing in terms of what the mother can describe. It is an effective approach. Why are we ignoring the traditional village doctor? They are the true community health workers.

VIII. Lunch and Keynote Remarks

*Yolly Roberson
Representative, Florida State Legislature*

Florida House of Representative Yolly Roberson, a Haitian American, gave a moving, personal testimonial of her "homecoming" to Haiti after more than 35 years of living in the United States. A portion of her remarks follows.

It is an honor and privilege to be here today. I moved from Haiti more than 35 years ago. This is my second trip back. Many friends have asked me to return, but for some reason, I always found an excuse: "It's not the right time." "I don't think it will be safe." But when Dr. Fournier sent me an invitation to the conference, I accepted immediately.

I was born in a little town called Mirebalais. My mother was one of the 80 percent of women who gave birth at home. I was lucky that everything went OK. I moved to Boston, Massachusetts, in 1976. Like most of my Haitian brothers and sisters, I left with only one objective: To go to America, get an education, make a lot of money, and return home. I never intended to stay in America, but when I was a teenager, I found myself into school, and I did what was important. When I thought about marrying and having a white picket fence, I envisioned it in Haiti, not in America.

I read the newspaper in French, and I read anything I could find about Haiti. I began my journey in America, but I saw myself there only on a temporary basis. I thought about returning home almost every day. But unfortunately, as the years went by, and the media painted such a bleak picture of Haiti, some the hope I had of going home started to fade. Eventually, the desire to return to Haiti subsided, and I became content, but never happy, to stay in America. But I never felt like I was at home. Always I longed for Haiti.

I returned in 1997, but all my hopes and my dreams of coming back had been shattered. I hated what I saw, and I decided that there was no way I could help. I gave up my dream of returning. When I heard about a missionary going to Haiti, I would give whatever I could: clothes, money—whatever they needed—because I wasn't going to deal with it. Like most of my Haitian brothers and sisters living abroad, I didn't give up on Haiti, but I felt helpless.

Last night I took a trip down memory lane. I remember walking the streets to school and passing a blood bank. And I remember hundreds of men, some of them emaciated, waiting to sell their blood so they could buy food. Now, 30 years have passed, and what has happened in those 30 years? What has happened to us as a people? I don't know if there is an answer to this question. If you don't think about it, it will go away. Well, it will not go away. This summit is evidence that we don't have to ignore it. We can join in with all you wonderful people doing a great job in Haiti and make it better. I think it can be better.

I was talking to a beautiful young woman who was telling me about the disability issues in Haiti. I know how important this is in America. A recent survey discovered that 10 percent of the population suffers from some form of disability. How can I stay away when 10 percent of the population is disabled, yet nothing is being done for them? Who knows? Perhaps I can do something.

My twin sister died from diarrhea when she was 2 years old. Diarrhea is the number one killer of children 0 to 4 years old. I am a victim of this health care system, and yet, out of fear, I was ready to be paralyzed by fear. My mother died when she was in her early 30s because of the poor health care system here. My family was not part of the very poor; we were middle class. Yet, these things happened to us. And with the economic situation now, it is probably one hundred times worse now than it was back then. The question again is, "How can you stay away?" How can we be uninvolved? How can we close our eyes? This summit suggests that we cannot live with ourselves if we continue to close our eyes. It's just not possible. When the primary killer of children between the ages 14 and 19 is AIDS, we cannot continue to close our eyes. I thank God for the work that you have done. I thank God for the work you continue to do, but we have so much more to do. And it is going to take effort by us all. Now that you have set the example, I think it is up to us to enter the challenge and work with you. I promise you I will do that.

We all tend to think that we were born to do something great, to work in our community, to give back to community. We have a big Haitian community in America, and we can do our work right there because it is more comfortable to do so. We have been blessed.

I think the Haitian Diaspora in America no longer knows what is going on in Haiti. I think the press portrays Haiti as a forgotten place that should just be left on its own. I am glad for people like you: people like Dr. Fournier, the ambassador, and community activists, and community leaders. I am so glad that when we were petrified with fear, you were not. You moved on. Instead of asking why you should be here, you asked, "Why not?" And you came.

This summit has been one of the most humbling, gratifying, and exciting experiences of my life. I am confident that Haiti is moving forward. I do not yet know what I can do, but I am here to learn. I will be ready to work with you, to do whatever I can.

Today on behalf of millions of my brothers and sisters around the world, it is my earnest privilege to thank you. I thank you for the work you have done. I thank you for the fire that has been keeping this going for so long. Imagine if you gave up? Imagine if you felt the desire and said, “Well, I can’t do this; it is too difficult.” Once again, I thank you. You did not have to step forward, but you understood that this issue is not a Democratic issue. It is not a black or white issue. It is one of humanity. You stepped forward. You answered the call. I am forever grateful, and so are my people. I love you.

IX. Dinner Remarks

Kimberly Green
President, The Green Family Foundation

Ms. Green spoke about trends in giving, donor relations, and innovative, alternative ways to philanthropy. A portion of her remark follows.

Most of you are probably not familiar with the Green Family Foundation. Our foundation was founded by my father, Steven Green, a former U.S. ambassador to Singapore, and by my mother, a former Miss United States of America. Our focus is HIV and AIDS education and prevention, early childhood education, homeless assistance, and promoting accessibility to the arts. We have initiatives in Florida, New York, California, South Africa, Southeast Asia, and now Haiti.

A new wave of philanthropy is now occurring in America and abroad. It includes philanthropists who are tired of the conventional ways of giving. Enterprises, such as the Internet, have produced a group of wealthy, very creative, new entrepreneurs. Many of these people want to give not only their money, but also their time to causes they truly believe in.

Many philanthropists—I especially—believe in the old expression, “Put your money where your mouth is.” This means not just writing a check, not just giving money to put our name on a building we might never visit, but playing an active, participatory role in the organization we support. To be involved means to be actively engaged in programs. Many organizations do not feel the need to actively engage their donors on a program level. They do not want to bother or annoy their donors for fear of missing future donations.

But engage your donors in activities. Help your donors to understand the richness of your culture, food, music, and art. Keep your donors aware. Do not leave them to believe that you are the only ones working in Haiti. Show them that they are part of a network of hardworking organizations.

Since the tragedy of September 11, people are more interested in understanding the differences and similarities of other cultures. One of the reasons I remain so passionate about working in Haiti is that as a donor and a friend, I was invited into your country, invited to share your culture, and invited into your homes. We have been invited to become part of the programming that promotes local citizens and their ownership of the programs, and to educate and train local people.

Project Medishare has provided us with that opportunity. The Green Family Foundation seeks out and develops programs that are community-based, community-run, and eventually community-owned—like many of the programs I heard about today.

A few years ago, I worked on a television show that took me to many countries. We focused on the effect of globalization on indigenous cultures. One thing I learned from that experience was the power of television and film to convey a message. That is why I have been working on a documentary film for the past year about health care in Haiti. We are far from finished, but the product has taken me all over the country, and it has enabled me to learn much about Haitian culture and history.

We have been to Pignon, the Schweitzer Hospital in Deschapelles, the Haitian Health Foundation in Fete, and Jérémie Hospital in Cap-Haitien. It is because of these hands-on, involved activities that we have continued to support and to come back to Haiti again and again—and to start telling everyone back in the States about how wonderful it is to work in Haiti.

Friday, June 27, 2003

X. Break-out Session Reports

A. Break-out Session 1: Orphans and Vulnerable Children

*Moderators: Dr. Art Fournier, University of Miami
Ms. Shelia Biamby, Catholic Relief Services*

Rapporteur: Dr. Fournier

According to Catholic Relief Services:

- Haiti has 103 orphanages with 11,000 children.
- 70 percent of the orphanages are licensed and registered.
- 15 percent provide care for disabled orphans.

The Problem:

- Haiti has 1.2 million orphans and vulnerable children.
- Of 400,000 orphans, 50 percent have a safety net, 50 percent have a family.
- 260,000 orphans have handicaps.
- Restavek = 250,000 HIV families.

Roles of the Ministries:

- Set standards
- Monitoring/enforcement
- Licensing
- Evaluation
- Public education
- Perform needs assessments
- School of Social Work

Problems:

- Lack of data
- HIV issues
- Sheer size
- Human resources
- Variable quality
- Variable motivation
- Lack of social workers
- Cost
- Funding
- "Graduation issues"
- Special problems of the disabled

Recommendations:

1. The ministry will commission an international organization to collect data regarding orphans and vulnerable children. It will establish a database and an orphan registry, and every orphan will have an identification number.

2. The ministry will establish standards for institution licensing:
 - An advisory council will assist in developing standards and a strategic plan.
 - Minimum health standards will be set for hygiene, nutrition, vaccination, TB screening, etc.
 - Incentives for meeting standards will be explored.
 - Staff will receive continuing education.
3. The government will open a school for social service.
4. The ministry will conduct public education regarding the causes of disability to encourage families to keep their children at home.
5. Children will undergo universal testing for HIV when they enter an orphanage.
6. Orphanages will be offered financial incentives to accept children with special needs (e.g., HIV-positive children, disabled children).
7. Fundraising:
 - More aggressive fundraising must occur among major philanthropic foundations.
 - A coalition of organizations that work with vulnerable children must be formed.
 - The Ministry will provide incentives (tax?) to Haitian businesses that contribute to organizations working with vulnerable children.

B. Break-out Session 2: Essential Obstetric Care/Prevention of Mother-to-Child Transmission of HIV/AIDS

*Moderators: Dr. Delia Rivera, University of Miami
Dr. Antoine Augustin, Management and Resources for Child Health*

Rapporteur: Dr. Augustin

Participants:

- 33 participants

Basic Data:

- Population: 8.6 million
- 260,000 pregnancy per year
- 13,000 HIV-positive
- 3,900 HIV-positive newborns

General Strategy:

- Primary prevention
- Reduce number of unwanted pregnancies HIV-positive women
- Secondary prevention: ARV prophylaxis
- Case management of HIV-positive mothers and newborns
- Community services
- Psychosocial support

Specific Interventions:

- Improving reproductive health and child health services
- Voluntary counseling and testing
- Optimal obstetric practices
- ARV prophylaxis : Zidovudine/Nevirapine
- Biological follow-up
- Appropriate feeding of newborns (artificial milk)
- HAART if indicated
- Minimal package of social services

Issues:

- Coverage/community outreach
- Social support
- Artificial milk
- Food
- C-section
- Identification of infected babies
- Stigmatization
- Indications for HAART
- Coordination

Activities of US-based PVOs in PMTCT, current and potential:

Current :

- CMMB 15,000
- St. François de Sales
- St. Boniface (Fonds des Blancs)
- Centre Rosalie Randau CS
- Hôpital Alma Mater, Gros Morne
- St. Jean, Limbe
- Sacre Cœur Milot
- Medishare PIH Thomonde with 1500 pregnancies
- Food for the Poor
- PIH: Canges, Lascahobas, Boucan Carre, Belladere
- Tulane University: support to MARCH

Potential :

- CARE Northwest: 9000
- FOCAS PV: 3000
- AMERICARES (drugs, milk formula)
- Rotary Club of Miami
- Mission MANNA
- Project Hope/CDS
- Total Pregnancies: 35,000

Recommendations:

- Improve coordination and exchange of information via quarterly UCS meetings and annual national meeting on PMTCT.
- Make PMTCT a part of VCT.

- Register all PMTCT programs with the UCS of the MOH.
- Conduct early diagnosis of infected infants.
- Provide artificial milk (premix); parallel behavior change communication program to preserve exclusive breastfeeding among HIV-negative mothers.
- Develop strong community support programs.
- Address specific programs for medical personnel: destigmatization; medical waste management.
- Assess possibility of providing triple therapy for pregnant women, continuation after birth dependent on CD4. (Do cost analysis. If woman has undetectable viral load, she can breast feed.)

C. Break-out Session 3: Family Health

*Moderators: Dr. Michel Dodard, University of Miami, Medishare
Dr. Jean-Robert Brutus, Family Health International*

Rapporteur: Dr. Michel Dodard

The work group addressed how the components of the minimum package of services (PMS) can be implemented according to the recommendations of the Ministry of Health.

Dr. Brutus presented the PMS, which consists of:

- Comprehensive management of childhood diseases (PCIME)
- Fight against STD/HIV
- Prenatal care, deliveries, and reproductive health
- Management of medical and surgical emergencies
- Availability and easy access to essential drugs
- Health promotion and patient education
- Basic dental care
- Fight against diseases transmissible by vectors (malaria, dengue, filariasis, anthrax)
- Latrine, garbage disposal, and drinking water supply programs

The workshop began by focusing on three major themes:

- Taking an inventory of the organizations represented and services they provide
- Possibly expanding the services they provide
- Recommendations

Thirteen organizations or groups were represented, and there was great diversity among them in terms of:

- The focus of their involvement, from very narrow to broad
- The length of time they had been involved in Haiti, from a few months to several decades
- Definitions of their respective missions

Before the question of expanding services or even delivering parts of the PMS could be addressed, some problems were identified, most under the headings of the environmental, logistical, and social contexts of health care. Some examples include:

- Transportation
- Lack of health care providers

- Establishment of a steady supply of medications, particularly for chronic illnesses
- Inability to move patients to a referral hospital
- Lack of refrigeration
- Problems with customs officials

As the group tried to address the specific issues in the PMS, a show of hands revealed that only one of the thirteen groups represented knew about the package, although all agreed that as it was written, the package is well conceived.

The group shared common experiences and exchanged technical information.

The group agreed that some parts of the PMS, such as medical and surgical emergencies, and prenatal care and delivery, were not realistically within the scope of the services that organizations in the work group could provide.

With only two exceptions, none of the organizations provided dental services.

There was a marked interest in water purification and latrine construction, but the lack of information about existing programs was apparent.

A few groups expressed interest in expanding their health education services, and some session members exchanged information about the use of different media (radio, video, education plays, or songs).

The discussions led to a set of recommendations:

1. Identify existing resources available to support programs.
2. Publish a directory of activities and services provided by departments or cities.
3. Produce a CD-ROM with all presentations and establish a database with linkages.
4. Seek assistance from customs officials to address bureaucratic hurdles.
5. Establish an information system to facilitate the sharing of transportation from rural areas to Port-au-Prince.
6. Establish an electronic communication network between NGOs working in Haiti.
7. Strengthen communication between MSPP and the NGOs, and establish and publicize MSPP's organizational tree.
8. PMS is a helpful roadmap, but together we must first build the road.

D. Break-out Session 4: Child Health

*Moderators: Dr. Bette Gebrian, Haitian Health Foundation
Dr. Yves Marie Bernard, USAID*

Rapporteur: Henry Perry

The Child Health group consisted of 17 workshop participants, including the MSPP Director of Family Health, and Ferna Victor, MSPP Director of the Expanded Program on Immunization (EPI).

The group reviewed the following basic child health statistics for Haiti:

- 8 percent of all live-born children die before their first birthday, and 12 percent die before reaching their fifth birthday.
- 39 percent of children have had symptoms of acute respiratory infection recently, and 26 percent of children have had diarrhea in the recent past.
- 23 percent of children have moderate or severe malnutrition.
- Only 34 percent of children younger than 5 years are fully immunized.

The group reviewed the priorities of the MSPP:

- Expand training in the integrated management of childhood illness (IMCI) concept and promote access to facilities that provide child care and that use IMCI protocols.
- Increase to 80 percent the proportion of children receiving childhood immunizations by their first birthday.
- Increase the number of children aged 6–24 months receiving vitamin A supplementation.

The group also reviewed the priorities for program implementation:

- Immunizations
- Vitamin A supplementation
- Growth monitoring and food supplementation for malnourished children
- Oral rehydration therapy for children with diarrhea
- Appropriate treatment for acute respiratory infections (including the use of antibiotics for those with pneumonia)
- Use of IMCI in appropriate settings

The obstacles to achieving these goals include frequent depleted stocks of vaccines and vitamin A, and logistical problems associated with the distribution of these items and with the cold chain (including a lack of functioning refrigerators).

The group proposed the following recommendations:

1. Affirm that the MSPP should give priority to the IMCI program and ensure the timely immunization of all children in Haiti.
2. All private groups should have access to information about how they can collaborate with the Ministry of Health's program through:
 - Orientation seminars on IMCI.
 - Access to training in IMCI protocols.
 - Learning about the plans and policies for the EPI program and how private groups can assist with its implementation.
 - Ensuring that these services be available at the local (i.e., UCS) level.
3. Establish a Web site on which materials from private and government programs could be posted.
4. Propose a stronger role for the UCS and private groups that participate in the UCS (i.e., via the transfer of resources to UCS with private groups receiving official governmental authorization to direct UCS activities with financial support obtained through international donors such as the Inter-American Development Bank).

5. Establish a procedure for identifying priority areas that need outside assistance in child health and other subject areas.
6. Publicize and make readily available information regarding which groups are working in which locations, and develop a map similar to the one that depicted the HS 2004 NGO network.
7. Identify “mentors” who can work with new entities that want to initiate work in Haiti. These could be institutions, organizations, projects, or individuals.
8. Identify and prioritize geographic areas of great need for new groups coming into Haiti who want to help.
9. Create a map that shows where all private groups work in child health in Haiti.
10. Bring private groups into the process of logistical support for the EPI program (cold chain and transport/delivery system).
11. Encourage local groups to actively promote dialogue between private and public providers, and convene similar summits in regions and districts.

XI. Resolving Operational Constraints and Facilitating Mobilization of External Resources

A. Customs and Clearance Issues

Dr. Guy D. Théodore
Director General, Comité de Bienfaisance de Pignon

Dr. Theodore fielded questions concerning custom and clearance issues.

Joyeuse Bernadotte
Ministry of Planning

Ms. Bernadotte delivered her remarks in French.

Dr. Thomas Streit
Coordinator of Vector-born Diseases, Sainte Croix Hospital

A portion of Dr. Streit’s comments follows.

I tend to get involved in custom issues when there are problems, such as when items are late or drugs are approaching expiration. We do not want our donors and collaborators to choose other groups or countries to help just because they think we are in remission, when, in fact, we are all working together.

What Americans are used to and expect are good communication of requirements, good customer service, transparency, efficiency, consistency, and fairness. We have to remember the public sector is not always as responsive as the private sector.

With the implementation of technology and much improved communications in the past few years, the Government of Haiti is providing increasing efficiency. Some time you can get a container in two days after it arrives in port. Customs has focused on doing a better job improving the system for regular shipments so that raw materials for industry can arrive in a timely fashion. The bigger shippers are getting better service.

Types of Custom Issues:

- Hand-carried packages and smaller shipments that arrive usually at the airport. Charges on these sorts of items can be inconsistent and unpredictable.
- Infrequent larger shipments by container. How much is the tax and what is it based on? How can we anticipate those costs (because we to be accountable to our donors).
- Infrequent larger shipments using a franchise. What are the paper requirements? We must pay particular attention to details when completing forms. We need to impress our colleagues in Haiti that these health materials are very important to the people of Haiti.
- Drug expiration and cold chain maintenance.

Related Issues:

- Brokers are unpredictable, and they blame us for a many things we are not responsible for. The brokers and customs also blame each other for problems. The questions are: What can the broker do or not do? Can the brokers be licensed or registered, and decertified if they misbehave? The broker issue is a weak link in the system.
- Can private organizations be registered and subject to monitoring and suspension? According to customs, there are groups among the NGO health importers that abuse the franchise privilege, and that import materials for resale. If we could police our colleagues and ourselves through registration, monitoring, and suspension for those who violate the policy, would we then have the force in numbers to negotiate better arrangements?
- What is the relationship of the MSPP to customs? Can we help get them working more closely together?

B. Required Authorizations and Approvals

Dr. Reginald Boulos

Director General, Centers for Development and Health

An excerpt of Dr. Boulos remarks follows.

CDS is a local indigenous private volunteer organization created in 1974, mostly by Haiti families of Middle Eastern origin, who wanted to give back to this country a little bit of what we had received in hospitality. It is a membership organization, and members contribute yearly to a fund that finances a portion of our activities.

We started the first clinic in 1974 in Cite Soleil, without the authorization or involvement of MSPP. There were very few health programs and no MSPP activity in Cite Soleil at that time. In 1978, we realized Plan International had a similar program in Cite Soleil, so we joined with them and became the CHAPI. We also received the first letter of authorization from the Ministry of Public Health and Population in 1978. This is when the ministry noticed us.

In 1980, we pulled more partners into the program by inviting not only Plan International, but also the Catholic Sisters of Charity and MSPP became a large part of the program. As we move

forward, the share of MSPP is growing as their involvement in the program is becoming more important.

The advantage of having a religious group involved is very beneficial. The group brings a dedication and availability. It also brings organizational and management skills and a culture of accountability that religious-based groups usually do not have.

Then 1986 was a milestone for us, because for the first time we signed a contract with MSPP to manage MSPP health centers that were no longer working. This project was the first integration of the MSPP into a joint project. Under the contract, the regional director of the MSPP was the technical director of the project. We used MSPP facilities and some limited personnel from the MSPP.

In 1989, in the Northeast Extension Part 1, a referral hospital was given to be managed by a private organization for the first time. This shows a gradual change in MSPP's thinking—that the public sector cannot do it alone and the private sector cannot do it alone. CDS is now at MSPP facilities, with MSPP staff and oversight; however, CDS is providing funding from USAID, providing management, and still directly providing services.

Our most innovative project to date is in 2003. For the first time, the MSPP's portion is bigger than that of CDS or the other partners because MSPP will manage its own centers, with technical assistance, managerial assistance, and funding from USAID, Project Hope, and CDS.

MSPP facilities and personnel are under MSPP management, and the regional director of the Northeast Department is chairman of the committee that will oversee this project.

Americans have been working with us since 1986, sending millions of dollars of medical supplies and equipment to CDS. This partnership is a very good example of what the U.S. PVO and the local PVO association can bring to both of us. Americans take care of the fundraising, organization, and shipments, which we are unable to do. We take care of customs, warehousing, distribution, and coordination. We distribute these supplies to more than 140 organizations. These supplies are distributed free to any registered PVO with the MSPP. CDS is an example of cooperation between a local PVO and the MSPP. It is the only institute of public health in Haiti, and it has two MSPP representatives on the board of directors.

The public sector believes we are pulling resources away from the sector. We have to convince the public sector that a rivalry for resources does not exist between the public and private sectors. Secondly, the public sector believes it loses control when a private organization takes over an area and starts providing services. The lack of resources for supervising and regulating makes the public sector think this way.

As the private sector, we want to be independent, but we cannot. It does not sit well with the public sector for us to do its supervision, so we have to agree that we cannot be secretive. We have to be transparent. We claim that the public sector is not transparent, but let us look at ourselves. Many of us in the private sector are also not transparent about what we do. There is much to be done on that issue by both sectors.

Finally, in dealing with the Government of Haiti and the MSPP, two words come to mind: Patience, patience.

Dr. Yvelte Biamby
Ministry of Public Health and Population

Dr. Biamby's presentation was delivered in French.

XII. Final Action Items

Dr. Guy D. Theodore
President of the Board, Haitian Association of Private Health Care Organizations (AOPS)

The technical presentations and breakout sessions were highly animated and productive, yielding 11 specific recommendations for follow-up after the summit, including:

1. Provide a report of the proceedings of the summit, by electronic mailings, Web site downloads, and limited direct distribution by USAID.
2. Prepare, update, and distribute a directory of U.S.-based organizations working in the health sector in Haiti. Include those that attended the summit, others that can be identified, and indigenous Haitian NGOs. The directory could be distributed along with the summit proceedings.
3. Create a new Web site or expand an existing one, and establish linkages with other sites that have similar missions, to facilitate coordination and information exchange.
4. Produce a list of Web sites that offer technical information and best-practice experiences in the priority public health programs that were discussed in the summit.
5. Establish a contact focal point and small support unit to assist in resolving problems faced by existing organizations and to facilitate the start-up and operation of new groups interested in working in Haiti. AOPS has agreed to take on this role, with direct support to be provided by the Ministry of Health and USAID.
6. Prepare a detailed information package on AOPS plans to facilitate the work of U.S.-based groups and organizations. Include Web site and other contact information.
7. Support the establishment of permanent NGO coordinating bodies in each of the 11 regional departments and administrative coordination bodies. USAID is currently working with Management Sciences for Health, AOPS, and the Ministry of Health on this.
8. Encourage the virtual and direct participation of summit participants in the development of the new five-year (2003–2008) National Strategic Health Plan.
9. Foster similar participation by summit participants in the preparation of detailed operational plans for an intensive campaign of activities to be organized this fall for the purpose of accelerating progress in meeting the public health priorities cited in the remarks by Minister of Public Health and Population, Dr. Henri-Claude Voltaire.

10. Provide all summit participants with the final plans for these programs to enable and encourage their full participation.
11. Plan to organize another national-level summit, at a minimum of every two years, with the next meeting to be held in 2005.

XIII. Closing Remarks

Brian Dean Curran
U.S. Ambassador to Haiti

In his closing remarks, Ambassador Curran discussed the following final recommendations:

1. Improve communication and coordination.
2. Increase synergy among program strategies and activities.
3. Facilitate active participation of all summit participants in the development and implementation of an intense set of activities to achieve targeted health improvements for Haitian mothers and young children, in conjunction with activities to mark Haiti's bicentennial celebrations.
4. Nurture and continue to strengthen ongoing public and private sector collaboration.

Ambassador Curran expressed confidence that the goals would be met, and he closed by saying, "We can and will continue to expand both the magnitude and the scope of our programs, while at the same time increasing the effectiveness and the impact of these activities toward achievement of better health and well-being for Haitian citizens."

**APPENDIX A:
Summit Agenda**

*Haiti
Health
Sector
Summit*

*Port-au-Prince
June 26 – 27, 2003*



SUMMIT PROGRAM

Wednesday, June 25th

Arrival in Port-au-Prince

Transportation Provided to Hotels

6:30 p.m.

Shuttles Depart Hotels

Transportation to the Ambassador's Residence

7:00 p.m.

Welcome Reception and Dinner

Residence of Ambassador Brian Dean Curran

Thursday, June 26th

7:30 a.m.

Shuttles Depart Hotels

Transportation to Hotel Montana

8:00 a.m.

Registration and Administration Announcement

Ms. Polly Dunford

Population, Health, and Nutrition Officer, USAID

8:30 a.m.

Welcoming Remarks

Ms. Pamela Callen, Acting Director, USAID

Mistress of Ceremony

8:35 a.m.

Remarks by the Minister of Public Health and Population

Dr. Henri-Claude Voltaire

8:50 a.m.

NGOs' Contribution to Achievement of Haiti's National Health Objectives

Mr. Paul Auxila, COP HS 2004 Contract

9:10 a.m.

Coffee Break

9:30 a.m.

Epidemiological Situation and Response

Panel Discussions:

1. **Situational Analysis**
Dr. Eric Gaillard, The Policy Project
2. **Prevention and Community Mobilization Activities**
Ms. Elsie Laudent
JHU Health Communication Partnership Project
3. **HIV/AIDS Scale-up and Restructuring of the Health Care Delivery System**
Dr. Marie Marcelle Deschamps
Secretary General, The Centers GHESKIO
4. **U.S. Government Assistance in the Sector**
Carl Abdou Rahmaan, Chief, USAID Haiti Population, Health, Nutrition, and Education Office

10:30 a.m.

Faith-Based Response

Presentations:

1. **Parish Twinning Program of the Americas**
Ms. Theresa Patterson, Director
Dr. Don La Font, Coordinator
Medical Mission Programs
2. **Catholic Medical Missions to Haiti**
Ms. Kathryn Bolles,
Program Director, Nutrition Program
3. **Lumiere Medical Ministries**
Ms. Sharon Kolb, Staff Director
4. **Catholic Medical Mission Board**
Mr. John F. Galbraith,
President and Chief Executive Officer

11:20 a.m.

Operational Relationship Models

Panel Discussions:

1. **University and Other Institutional Twinning Programs**
 - Dr. Arthur Fournier, University of Miami, Family Practice Residency Program/HUEH
 - Dr. Serena Koenig
Harvard University/Partners in Health

- Dr. J. Michael Taylor
Konbit Sante/Hospital Justinien

2. Private/Public Partnerships

- Dr. Claude Surena, Chief of Staff
Ministry of Public Health and Population Cabinet
- Dr. Sandra Laumark, Country Director
CARE International
- Mr. Robert Northrup, Project Hope

12:20 p.m.

Participants Join Break-out Sessions:

1. Break-out Session I:
Orphans and Vulnerable Children
Moderators:
Dr. Art Fournier, University of Miami
Ms. Shelia Biamby, Catholic Relief Services
2. Break-out Session II:
Essential Obstetric Care/ Prevention of Mother to Child Transmission of HIV/AIDS
Moderators:
Dr. Delia Rivera, University of Miami
Dr. Antoine Augustin, Management and Resources for Child Health
3. Break-out Session III:
Family Health
Moderators:
Dr. Michel Dodard, University of Miami
Dr. Jean Robert Brutus, Family Health International
4. Break-out Session IV:
Child Health
Moderators:
Dr. Bette Gebrian, Haitian Health Foundation
Dr. Yves Marie Bernard, USAID

12:30 p.m.

Break-out Sessions Begin

1:30 p.m.

Lunch and Keynote Remarks

Representative Yolly Roberson, JD, RN
Florida State Legislature

3:00 p.m.

Break-out Sessions Continue

5:00 p.m.

Adjourn for the Day

- 6:30 p.m.** **Shuttles Depart Hotels**
Transportation to AOPS Dinner
- 7:00 p.m.** **Dinner Reception Organized by the Haitian Association of Private Health Care Organizations (AOPS)**
Keynote Speaker:
Ms. Kimberly Green, The Green Foundation

Friday, June 27th

- 8:00 a.m.** **Shuttles Depart Hotels**
Transportation to Hotel Montana
- 8:30 a.m.** **Review of Day 1 Discussions**
Ms. Polly Dunford, Population, Health, and Nutrition Officer, USAID
- 9:00 a.m.** **Report and Discussion of Break-out Sessions:**
1. Break-out Session I:
 Orphans and Vulnerable Children
 2. Break-out Session II:
 Essential Obstetric Care/ Prevention of Mother to Child Transmission
 3. Break-out Session III:
 Family Health
 4. Break-out Session IV:
 Child Health
- 10:30 a.m.** **Coffee Break**
- 10:45 a.m.** **Resolving Operational Constraints and Facilitating Mobilization of External Resources**

Panel Discussions:

1. **Customs and Clearance Issues**
 - Dr. Guy D.Théodore, Director General, Comité de Bienfaisance de Pignon
 - Dr. Thomas G. Streit, Coordinator for Vector-borne Diseases, Hopital Sainte-Croix
 - Ms. Joyeuse Bernadotte, Ministry of Plan

2. Required Authorizations and Approvals

- Dr. Reginald Boulos, Director General, Centers for Development and Health
- Dr. Yvelte Biamby, DDRH, Ministry of Health

12:00 p.m.

Next Steps

Dr. Guy D. Théodore, President of the Board, Haitian Association of Private Health Care Organizations

12:15 p.m.

Closing Remarks

Ambassador Brian Dean Curran

**APPENDIX B:
Participants List**

**Haiti Health Sector Summit
June 26–27, 2003**

Participants List

Abdou Rahmaan, Carl	USAID
Alvarez, Mario	Université d'État d'Haïti
Amayun, Milton	World Vision International
Anderson, Steve	Mission Evangelique Baptiste Du Sud D'Haïti
Andrinette, Cadet	Plan Haiti
Aristide, Yvone	National Organization for the Advancement
Augustin, Antoine	Management and Resources for Child Health
Auxila, Paul	Management Sciences for Health
Avignon, Nicaise	Christian Operation for Health, Education, and Development
Baguidy, Micheline	Foundation of Compassionate American Samaritans
Baker Vorbe, Marie Louise	Groupe de Support Contre Le Cancer
Baptiste, Joseph	National Organization for the Advancement
Barnard, Ruth	University of Michigan
Bazemore, Curtis	National Organization for the Advancement
Bazemore, Shiela	National Organization for the Advancement
Bennett, Bernice	American International Health Alliance
Berquist-Jules, Deborah	Hôpital Albert Schweitzer
Biamby, Sheila	Catholic Relief Services
Biamby, Yvelte	Ministry of Health
Bolles, Kathryn	Children's Medical Missions of Haiti
Bonnet, Jean-Paul	International Modular Medical & Education Delivery Systems
Boulos, Regiland	CDS
Bowen, Carol	National Organization for the Advancement
Brady, Sandra	American Red Cross
Branker, Carl	Carrying Bread to the Multitude

Brice, Dina	National Organization for the Advancement
Brice, Nadia	National Organization for the Advancement
Brice, Sylvia	National Organization for the Advancement
Bruno, Antoine	National Organization for the Advancement
Brutus, Bernard	Healing Hands for Haiti
Calhoun, Cynthia	Haiti Medical Mission Task Force
Callen, Pamela	USAID
Calloway, Laine	The Episcopal Diocese of Western North Carolina
Cameron, Jeff	Healing Hands for Haiti
Caniff, Nanette	St. Boniface Hospital
Carpenter, Rand	Mennonite Central Committee
Carstedt, Peter	The Clinton Foundation
Casseus, Carme Idrelle	National Organization for the Advancement
Casseus, Jean	National Organization for the Advancement
Charles, Emile	
Charlotin, Marlene	United States Agency for International Development
Chery, Marie	Project Medishare
Codada, Shirley	National Organization for the Advancement
Cole, Donald	National Organization for the Advancement
Coleman, Pamela	National Organization for the Advancement
Courey, Emily	UN Foundation
D'Amico, Judith	Plan International
Deschamps, Marie Marcelle	
Desrosiers, Paultre	
Destine, Jonias	Hôpital Lumere Bonaface
Désulmé, Geneviève	Groupe de Support Contre le Cancer
DeVoe, Bob	Lifeline Christian Mission

DeVoe, Gretchen	Lifeline Christian Mission
Dickey, Vanessa	The Simeus Foundation
Dodard, Michel	University of Miami
Dodds, Sally	University of Miami
Dorsainvil, Jean Robert	Mission MANNA
Dorsinville, Nancy	The Clinton Foundation
Duncan, Gina Ferrus	Healing Hands for Haiti Foundation
Dunford, Polly	USAID
Durandisse, Sheyla	Haitian Resource Development Foundation
Eckhoff, Cristina	Centre Medical Beraca
Eckhoff, Paul	UFM International
Elam, Bonnie	The Haiti Connection
Elizee Legros, Josephine	Haitian Resource Development Foundation
Estime, Yvonne	National Organization for the Advancement
Eustache, Laurent	The Futures Group
Exilus, Wadisse	The Simeus Foundation
Fontana, Mrs. Peter	
Fontana, Peter	Hope For Haiti Foundation
Fournier, Arthur	University of Miami
Francois, Dianne Jean	Catholic Medical Mission Board
Francoise, Emmanuel	National Organization for the Advancement
Fritschner, Ann	
Funcap, Essud	National Organization for the Advancement
Funcap, Essud	National Organization for the Advancement
Gaillard, Eric	The POLICY Project
Galbraith, John	Catholic Medical Mission Board
Garms, Dientha	World Vision

Gautier, Max	National Organization for the Advancement
Gay, Emmanuella	The Haitian League
Gebrian, Bette	Haitian Health Foundation
Gilbert, Aimee	AmeriCares
Gleason, Susan	Healing Hands for Haiti
Goff, Michael	The Clinton Foundation
Green, Kimberly	The Green Family Foundation
Greene, Kim	Dr. John T. MacDonald Foundation
Grieco, Gregory	Renewable Resources SG
Guillaume, Jacques	
Hansley, Luther	Harvest International, Inc.
Hazel, Edouard	Association of Haitian Physicians Abroad
Hedgepath, Pam	Lumiere Medical Ministries
Herrington, James	UN Foundation
Hirsch, Phillipe	Haitian Association of Private Health Care Organization
James, Dula	Catholic Relief Services
Jean-Baptist, Gary	National Organization for the Advancement
Jean-Louis, Eustache	Center for Community Health, Education, and Research
Jennings, Jessica	The Synergy Project
Jerome, Eric	Association of Haitian Physicians Abroad
Johnston, Andrew	The Clinton Foundation
Jonas, Destine	Hôpital Lumere Bonaface
Jones, Malachi	National Organization for the Advancement
Joseph, Gabriel	Hôpital Albert Schweitzer
Josma, R.	The Haitian League
Keenan, Gerald	Sacred Heart Parish
King, Simon	Video Communications Corp.

Koenig, Serena	Partners In Health
Kolb, Sharon	Lumiere Medical Ministries
Kuehner, JoAnne	Hope for Haiti
La Font, Don	
La Font, Joyce	
Labissiere, Berthie	National Organization for the Advancement
Labissiere, Gertha	National Organization for the Advancement
Labissiere, Mirline	National Organization for the Advancement
Larned, F. Stephen	Konbit Sante Cap-Haitien Health Partnership
Larned, Polly	Konbit Sante Cap-Haitien Health Partnership
Latimer, Anne	The Synergy Project
Laumark, Sandra	CARE International
Lauredan, Bernier	
Laurent, Elsie	JHU Health Community Partnership Project
Legros, Jessie	Florida Border Health Education and Training
Leilani, David	National Organization for the Advancement
Lozier, Maggie	Mission MANNA
Maceno-Avignon, Madeleine	Christian Operation for Health, Education, and Development
Madison, Lori	National Organization for the Advancement
Magloire, Bette	Haitian Health Foundation
Mathai, Rabia	Catholic Medical Mission Board
McBean, Michelle	National Organization for the Advancement
Melamed, Yolanta	Global Health Action
Michaud, Lesley	World Vision
Modesta, Lorenzo	National Organization for the Advancement
Moise, Rudy	National Organization for the Advancement
Morquette, Hubert	World Relief
Myrthile, Gilbert	The Haitian League

Myrthile, Nadege	The Haitian League
Nickerson, Nathan	Konbit Sante Cap-Haitien Health Partnership
Noel, Guy	Private Practice Physicians
Northrup, Robert	Project HOPE
Parisienne, Maye	National Organization for the Advancement
Parisienne, Serge	National Organization for the Advancement
Patterson, Theresa	Haiti Parish Twinning Program
Paul, Henry	National Organization for the Advancement
Paul, Joseph	Association of Haitian Physicians Abroad
Péan, Françoise	Groupe de Support Contre le Cancer
Perlmutter, Jessica	United Way
Perry, Henry	Hôpital Albert Schweitzer
Petal, Shilpa	National Organization for the Advancement
Philogene, Ketty	National Organization for the Advancement
Pierre, Michael	Konbit Sante Cap-Haitien Health Partnership
Pierre Canel, Iddy	National Organization for the Advancement
Polidor, Yolène	The Simeus Foundation
Prezeau, Magaly	Florida International Volunteer Corps
Prince, Sonja	National Organization for the Advancement
Pun, Raymonde	Food for the Poor, Inc.
Racine, Gladys	Toussaint Louverture Historical Society
Remy, Christophe	Video Communications Corp
Rene, Marie-Pologne	The University of The Haitian Academy
Reuben, Teresa	National Organization for the Advancement
Rivera, Delia	University of Miami
Roberson, Yolly	Florida State Legislature
Robinson, Rose Miles	Community Coalition for Haiti

Roger, Marc	Florida International Volunteer Corps
Romain, Michèle	Groupe de Support Contre le Cancer
Royes, Heather	Food for the Poor, Inc.
Rutland, Alice	Mission MANNA
Saintville, Ulki	National Organization for the Advancement
Sanon, Christian	Organization Rome Haiti
Sanon, Christiane	Vasco Imaging Center
Schiegg, Nicole	The Synergy Project
Seagel, Joel	National Organization for the Advancement
Silva, Eddy	Complexe Isae Jeanty
Simeus, Dumas	The Simeus Foundation
Smythe, Patrick	
Speraw, Cathy	Children's Medical Missions of Haiti
St. Preux, Jonathan	The Haitian League
Stokes, Vikki	Lumiere Medical Ministries
Storms, Dory	Hôpital Albert Schweitzer
Streit, Thomas	Hôpital Sainte-Croix
Sumilas, Michelle	Global Health Council
Surena, Claude	Ministry of Public Health and Population Cabinet
Swanson, Suzanne	United Church of Christ
Taylor, J.Michael	Konbit Sante Cap-Haitien Health Partnership
Taylor, Richard	Foundation of Compassionate American Samaritans
Theodore, Guy	
Thilus, Wilnes	Caritas
Thomas, Danny	Harvest International, Inc.
Thomisee, Karen	Mission MANNA
Timmons, Samantha	Konbit Sante Cap-Haitien Health Partnership

Tippenhauer, Robert	Global Health Action
Tuitt, Kathleen	Caribbean Representative Baptist Health
Tukpah, James	National Organization for the Advancement
Waesche, Dana	AmeriCares
Ward, Norma Elaine	National Organization for the Advancement
Wearlle, Bill	National Organization for the Advancement
West, Nathaniel	National Organization for the Advancement
Wiggins, James	Global Health Council