June 2010

Haiti: How Can I Help?

Models for Donors Seeking Long-Term Impact

Health

Livelihoods

Education

The Center for High Impact Philanthropy

School of Social Policy & Practice I University of Pennsylvania

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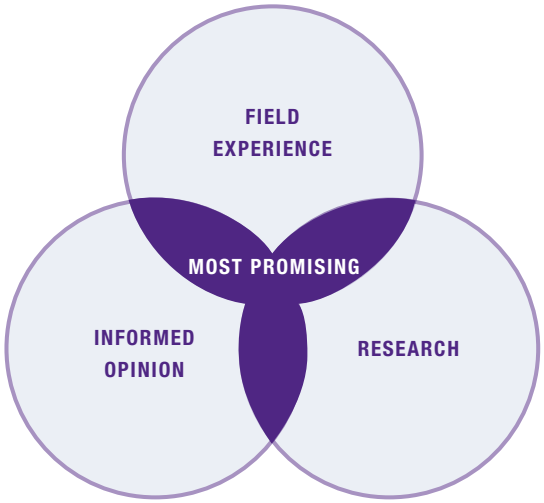
ABOUT THE CENTER FOR HIGH IMPACT PHILANTHROPY

The nonprofit Center for High Impact Philanthropy was founded in 2006 by Wharton alumni and is housed at the University of Pennsylvania's School of Social Policy & Practice. Our aim is to provide information and tools to help philanthropists determine where their funds can have the greatest impact in improving the lives of others. With expertise in business, medicine, law, and public and social policy, our team brings a multidisciplinary approach, in-depth knowledge of research methods, and seasoned judgment to the analysis of high impact philanthropic opportunities.

OUR MULTI-PERSPECTIVE, EVIDENCE-INFORMED APPROACH

To meet our goal of providing smart, practical guidance to individual philanthropists, we synthesize the best available information from three domains: research, informed opinion, and field experience. By considering evidence from these three sources, we seek to leverage the strengths while minimizing the limitations of each. We believe the most promising opportunities exist where the recommendations of these three domains overlap.

SOURCES OF INFORMATION



FIELD EXPERIENCE
- Practitioner insights
- Performance assessments
- In-depth case studies

INFORMED OPINION
- Expert opinion
- Stakeholder input
- Policy analyses

RESEARCH
- Randomized controlled trials and quasi-experimental studies
- Modeled analyses (e.g., cost-effectiveness)

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Model In Practice on this page

Cover photo collage, designed by Minh Chau. Photos courtesy of Partners In Health, Friends of Hôpital Albert Schweitzer, Catholic Relief Services, Fonkoze, Save the Children, International Rescue Committee

Image provided by Partners In Health.

You have heard a lot about Haiti, much of it focused on the poverty that existed before the January 12, 2010 earthquake and the devastation that followed. In this guide, we outline ways that donors can help Haitians develop the capacity they need to build a brighter future for themselves, their communities, and their nation. None of Haiti's problems are unsolvable. As attention shifts from immediate disaster relief to building the country back better, we show you nonprofit models with proven track records for making lasting impact.

The 7.0-magnitude earthquake that struck the island nation resulted in a large-scale humanitarian crisis: the death toll has been estimated at well over 200,000; an estimated 300,000 people were injured; and an estimated one million have been left homeless. The earthquake destroyed the commercial and political capital of the country — Port-au-Prince — prompting a dramatic reverse migration to the impoverished, rural communities many Haitians had fled in search of better opportunities. The earthquake revealed the acute underdevelopment that has plagued Haiti for decades and compounded the poverty, destroying what little infrastructure and capacity had previously existed.

In the immediate aftermath of the earthquake, the international community generously responded with disaster relief. But as the celebrity appeals fade and the hard work of building back better begins, we set out to answer the question: ***"What can donors support that will lead to long-term impact?"***

What's in this guide

To help donors understand where high-impact opportunities exist, our multidisciplinary team spoke with dozens of people, including nonprofit practitioners working in Haiti, members of the Haitian Diaspora who were in daily contact with loved ones in Haiti, development experts, donors with long-

term projects in Haiti, and researchers who had conducted assessments of the models described in this guide. We reviewed nonprofit program and financial information, listened in on conference calls reporting on the status of relief efforts, and met with individuals designing programs aimed at improving Haiti's long-term development prospects. This guide is the result of our efforts.

As always, our hope is that by doing much of the legwork for you, we provide the kind of independent, practical advice that will help you move from concern and good intentions to impact.

Our focus on Health, Livelihoods, and Education

This guide is divided into three major sections: health, livelihoods, and education. We focus on these areas for the following reasons:

- These areas represent the three pillars of socioeconomic development; without significant improvements in each of these areas, Haiti will not be able to move past the current devastation.
- Promising nonprofit models already exist in each area and are currently operating in Haiti. Models in these areas offer effective and cost-efficient opportunities for donors to help.
- The three areas are interrelated so that investments in one area yield gains in others. In fact, most programs are integrated across all three sectors.

The models are similar in that they all emphasize capacity building. All are responsive to local needs, are staffed almost entirely by Haitians, and are designed to support and strengthen the government's effectiveness. By involving affected communities in their own recovery and rebuilding, these models have produced sustained impact — positive change that lasts long after you make a donation.

What you can expect in each section

This guide was written for individual donors seeking long-term impact in Haiti. Each section includes:

- A brief analysis of the current situation.
- A description of high-impact models to improve the situation, including an estimate of the impact and cost of each model.
- Examples of the Models in Practice currently operating in Haiti to help donors understand how nonprofits target these core issues effectively.
- Contact information for nonprofits mentioned.

We focus our analysis on identifying effective models rather than on rating specific nonprofits. This is because much of the available evidence on impact and cost-effectiveness exists only at the level of the model. In addition, many donors, particularly major individual donors, are looking for guidance to inform their own entrepreneurial efforts or help them improve the effectiveness of their current philanthropic activities.

To help donors understand how nonprofits apply these models in real-life settings, our Models In Practice provide concrete examples of nonprofit agents implementing the various models. There are many other nonprofits working in Haiti whose efforts we don't describe in detail. For donors considering other nonprofits, we outline the essential components to look for when assessing whether a program can deliver the kind of results we describe in this guide. You can find these lists at the end of each section.

While this guide focuses on efforts in Haiti, the models we describe have been effective in other developing countries. At the end of the guide, we list examples of other places where the models have achieved impact. We also offer tips for giving to any nonprofit described in our Models In Practice.

This guide represents the best insight we can offer given the information currently available. We welcome continued input and are exploring ways to update this material to incorporate new information and new developments. To receive notices of updates to this guide, please contact **impact@sp2.upenn.edu**.

Haiti - Reference Map

OCHA

Map provided courtesy of the UN Office for the Coordination of Humanitarian Affairs

Visit: ochaonline.un.org/haiti, www.reliefweb.int

JUDITH'S STORY

"We no longer had a home and no longer had our mother… Since I lost my home, I now have to walk two hours per day to get to school each day, 6km in total. It is tiring but I know that I must continue my studies if I want to be something in life. Sometimes I want to give up but a little voice tells me to say determined, to keep going on and I am going to do this for my mother, for my family. It's my reason for living."

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Adapted from: UNICEF. (2010, May 26). Field notes: Blogging on UNICEF's child survival work in the field: The day my world crumbled. Retrieved June 8, 2010, from http://www.whitebandaction.org/en/readings/global-poverty/10-05-26/day-my-world-crumbled

Image provided by Friends of HAS

Image provided by Partners In Health

Image provided by Partners In Health

OPPORTUNITY 1: HEALTH

Supporting Community-Based Primary Care Systems

Haiti: How Can I Help?

June 2010

Opportunity for Philanthropists

Even before the earthquake, almost half of Haiti's population lacked access to healthcare. Yet a proven, cost-effective model exists for bringing healthcare to even the poorest, rural communities. Community-based primary healthcare systems reach people where they live. They provide access to essential prevention and treatment, health education, advanced hospital care and essential surgery in emergencies, and programs addressing the root causes of poor health (e.g. access to clean water and nutrition). In this section, we provide two examples of nonprofits, each with over two decades of results from successfully implementing this model in Haiti. Their experience demonstrates how this comprehensive approach can create a sustainable system. By supporting models such as these, you can ensure the health of Haitians, not just after the earthquake, but for generations to come.

THE CONTEXT

This section focuses on cost-effective, proven models for addressing the health needs of the people in Haiti.

Immediately after the January earthquake, much of the initial health focus was on trauma care to save the lives of those seriously wounded, thousands of whom suffered crush wounds requiring emergency surgery such as amputations. Yet even before the earthquake, Haiti's public health system was ill-equipped to meet the high level of need. Almost half of the Haitian population lacked access to healthcare, a fact reflected in high child and maternal mortality rates—the worst in the Western Hemisphere (SEE TABLE 1 BELOW).

The current needs reflect many of the same health problems that Haiti faced prior to the earthquake. However, the earthquake destroyed precious medical facilities and killed key medical personnel. Haiti's public health system is now even less capable of responding to the increased need.

Yet the primary causes of sickness and death in Haiti continue to be mostly preventable and treatable — infectious diseases such as diarrhea and pneumonia in children, HIV and tuberculosis in adults, malnutrition, injuries, and complications during childbirth.

TABLE 1: COMPARING HEALTH INDICATORS[1]

	Haiti	Dominican Republic	United States
Infant mortality rate (per 1000 live births)	54	27	7
Under-5 mortality rate (per 1000 live births)	72	33	8
Life expectancy at birth in years	61	73	79
Lifetime risk of maternal death	1 in 44	1 in 230	1 in 4,800
Percentage of population using improved water sources*	58%	95%	99%
Percentage of population using improved sanitation**	19%	79%	100%
Percentage of births attended by skilled personnel	26%	98%	99%
Percentage of newborns protected against tetanus	50%	86%	N/A
Percentage of under-5's moderately or severely underweight	22%	4%	2%

** Improved water sources include household connections, public standpipes, boreholes, protected dug wells, protected springs, and rainwater collections.*
*** Improved sanitation facilities include public sewer connections, septic system connections, pour-flush latrines, simple pit latrines, and ventilated pit latrines.*

GREAT BANG FOR BUCK: COMMUNITY-BASED PRIMARY HEALTHCARE SYSTEMS

Average cost: $20-25 per person/year for access to essential evidence-based health interventions at the local level.

Representative impacts:

- decreased child death rates: 58% lower risk of death before age 5 compared with the rest of Haiti
- greatly improved HIV and tuberculosis survival rates
- marked drop in maternal death rates and neonatal tetanus in communities served by the health systems

Cost per impact: Results from Hôpital Albert Schweitzer (HAS) Health System have been translated into an estimated return on investment:

- cost per year of life saved ~ $40
- cost per child death averted ~ $2,775

(SEE MODELS IN PRACTICE FOR SOURCES OF THIS DATA.)

HOW YOU CAN CHANGE THE SITUATION

The good news is that comprehensive community-based primary healthcare models have demonstrated success in improving the health and well-being of the populations they serve, especially children. In this section, we describe two examples of this model currently operating in Haiti:

- Hôpital Albert Schweitzer (HAS) Health System
- Zanmi Lasante/Partners In Health (ZL/PIH)

By emphasizing primary and preventive care, with links to surgery and hospital care when needed, these programs are not only highly effective but also highly cost-efficient. Both have decades of experience achieving results in Haiti and could be replicated and scaled up with additional donor support. They share the following characteristics that make them effective:

- They deliver preventive care and treatment at the household level through outreach by salaried community health workers, mobile clinics, and health educators. In addition, links to quality clinics and referral hospitals mean more advanced care is available when needed (e.g., surgery to save a mother's life during complicated childbirth).
- They address root causes of illness in Haiti through programs or partnerships focused on clean water, sanitation, food security and improved agriculture, income generation, and basic health literacy and education.
- They build capacity of the public system to ensure the long-term sustainability of the programs and their impact. For example, the models provide a training site for health professionals in the public system.
- Their models are scalable and sustainable. They address local conditions such as ensuring access to consistent quality care in rural, mountainous regions. They establish reliable supply chains and human resources networks. They also have experience partnering with the public sector.

To help philanthropists better understand how this comprehensive model is put into practice, we provide two examples of nonprofits with more than 25 years of experience operating in Haiti. Founded more than 50 years ago, the first agent, HAS, pioneered the model in the Artibonite Valley of Haiti and since then, many other nonprofits have replicated its structure. The second example, ZL/PIH, started out in the Central Plateau region at a hospital in Cange, and rapidly expanded delivery of primary care, HIV, and tuberculosis services through its community health worker-focused model. At the end of the section are descriptions of two additional nonprofits implementing the community-based primary healthcare model in other regions of Haiti and tips on assessing other agents not mentioned here.

MODELS IN PRACTICE:

Community-Based Primary Care: Example 1 - Hôpital Albert Schweitzer Haiti (HAS)

About the model: Hôpital Albert Schweitzer (HAS) is an integrated system of primary health care, hospital care, and community development initiatives. It includes:

- A community health program with routine visits to all households by salaried health agents (agents de santé), mobile clinics run by nurses, a system of midwives for reproductive health, tuberculosis and HIV programs, and community health volunteers (1 for every 15 houses) who facilitate peer health education. Six health centers/dispensaries located throughout the service area provide basic preventive and curative care. A continuous census tracks program effectiveness.
- A full service referral hospital in Deschapelles, operated by a predominantly Haitian staff including surgeons, medical doctors, nurses, and medical assistants. It serves as the official district hospital in the public system. A longstanding partnership with a U.S. orthopedic group has enabled HAS to perform complex orthopedic procedures not otherwise available in most of Haiti.
- Community development initiatives for water and sanitation, literacy training, improved veterinary care, reforestation, sustainable farming techniques, and micro-enterprise.

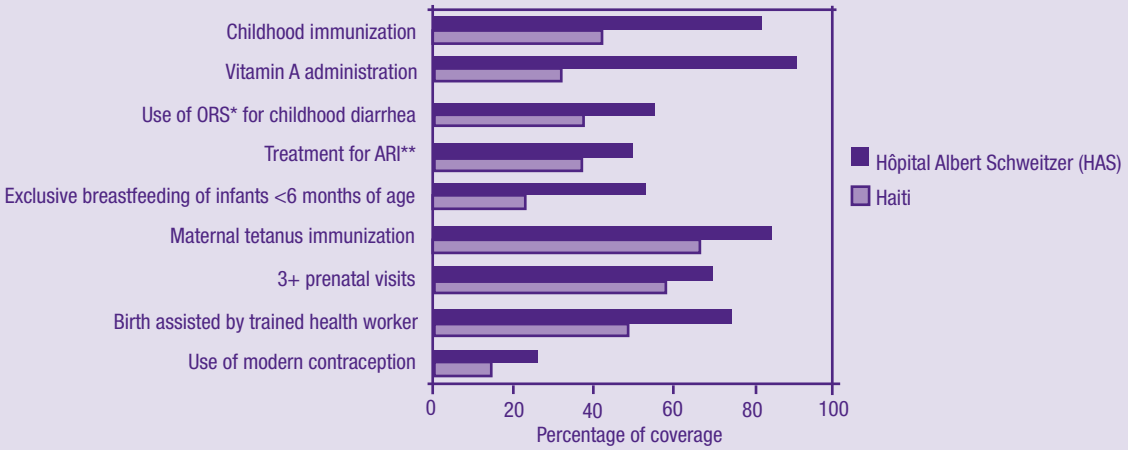
The HAS model has been replicated by other NGOs throughout rural Haiti and adapted in other developing countries. The HAS system did not suffer damage from the earthquake and has been able to play a key role in providing care to the injured and displaced. For example, HAS was the first hospital to have an operational prosthetics lab to serve amputees from the earthquake.

Nonprofit agent: Inspired by the work of Dr. Albert Schweitzer in Africa and his ethic of reverence for life, an American couple Dr. William Larimer Mellon Jr. and Gwen Grant Mellon founded HAS Haiti in 1956. Since its founding, the HAS system has served the rural population of mostly subsistence farmers — now 300,000 people and growing — which lives within a 610 square-mile area of the Artibonite Valley in central Haiti. This region is about 75 miles northwest of Port-au-Prince, the Haitian capital.

Impact: Recent analyses provide convincing evidence of the substantial sustained impact and cost-efficiency of this model.

When assessing health system results, the first question to ask is, "Does the target population receive key health services such as immunizations, prenatal care, and treatments for life-threatening childhood illnesses?" As you can see in Figure 1 below, the proportion of the population reached was 1.5 to 2 times higher in the HAS system than in the rest of Haiti for all of the most important health interventions in 2000.[2] For example, the percentage of children receiving the recommended series of immunizations was 2.4 times greater in the HAS service area.

FIGURE 1: HAS - ACCESS TO PROVEN INTERVENTIONS, YEAR 2000



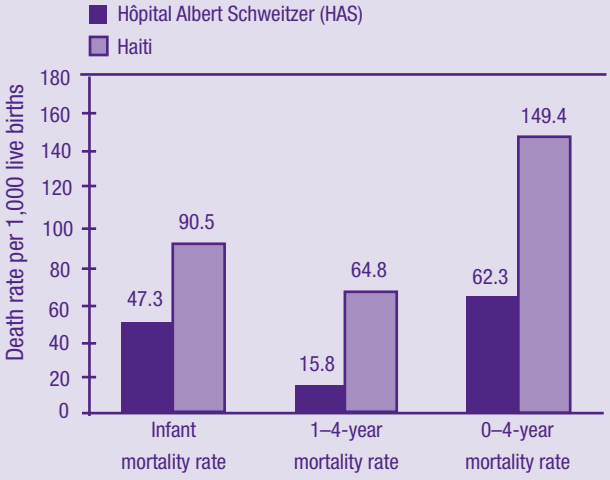
** Oral rehydration solution*
*** Acute respiratory infections*
Source: Adapted from Perry, H., Cayemittes, M., Philippe, F., et al. (2006). Reducing under-5 mortality through Hôpital Albert Schweitzer's integrated system in Haiti. Health Policy Plan, 21(3), 217–230 by permission of Oxford University Press.

MODELS IN PRACTICE (CONTINUED):

Once you have confidence that the health system has improved access to key, evidence-based interventions, you then want to know whether this improved access to and increased use of health services produces positive health outcomes. You would particularly want to see declines in mortality (death) rates for vulnerable populations such as newborns and children under 5.

Research has shown that the HAS system has significantly improved health outcomes for children under 5 for more than three decades.[3] As Figure 2 illustrates, risk of death before age 5 was found to be 58% lower and risk of death before age one was 48% lower in the HAS service area.

FIGURE 2: HAS - MORTALITY IMPACT, 1995-1999



Source: Adapted from Perry, H., Cayemittes, M., Philippe, F., et al. (2006). Reducing under-5 mortality through Hôpital Albert Schweitzer's integrated system in Haiti. Health Policy Plan, 21(3), 217–230 by permission of Oxford University Press.

This is in comparison to populations in rural Haiti with similar socioeconomic and educational levels between 1995 and 1999. In addition, total fertility rates were 29% lower in the HAS service area than in the rest of rural Haiti, a reflection of improved access to women's health and reproductive health services. Furthermore, HAS has reduced the rates of illness and disability within its service area.[4] Overall, the HAS system has led to an improved quality of life among the population it serves.

Costs/resources required: The total per capita annual cost of the HAS program was approximately $21 in 2000.[5] Two benchmarks illustrate the cost-efficiency of this model: 1) The Commission on Macroeconomics and Health of the World Health Organization estimates that it costs $34 per capita to provide the essential package of interventions in developing countries and 2) the average per capita health spending in high-income countries is more than $2,000 per year.[6]

The impressive results of HAS were achieved at an affordable cost with fewer doctors and hospital beds per capita than in the rest of Haiti. Instead of using more doctors, HAS employed double the number of nurses than are found in the rest of Haiti. These professionals were supported by three cadres of community health workers to ensure that services reached the communities in need.

Cost per impact: By comparing child survival rates within the HAS service area to rates in the rest of Haiti between 1956 and 1999, researchers have estimated that the HAS system preserved 1 million additional years of life among children under 5 during 43 years of operation. Considering operating costs for programs directed at mothers and children during this period, they estimated:

- Cost per child (under age 5) death averted ~ $2,775
- Cost per year of life saved ~ $40[7]

These figures suggest that, compared with other health interventions and international benchmarks, the HAS system is highly cost-effective, providing significant results at an affordable cost.[8]

Image provided by Friends of HAS

MODELS IN PRACTICE (CONTINUED):

How your dollars can help: Philanthropic capital is especially needed now because the population that HAS serves has increased from 300,000 to 450,000 as thousands of displaced Haitians from the capital have settled in the Artibonite Valley. Many of the displaced have not had previous access to medical care and will need basic health services (e.g., immunizations) in addition to treatment for injuries they sustained in the earthquake. Since the earthquake, HAS has responded to the needs of new amputees through the creation of a long-term prosthetics and rehabilitation center in partnership with the Haitian Amputee Coalition. This initiative includes expansion of a training program for rehabilitation technicians. Donor support can help extend community health and essential services to newly arrived populations and allow this comprehensive system, with more than 50 years of sustained results, to expand its reach.

Nonprofit contact: Natalie Hoffman at (412) 361-5200 or visit the HAS website: http://www.hashaiti.org.

Community-Based Primary Care: Example 2 - Zanmi Lasante/Partners In Health

About the model: Zanmi Lasante/Partners In Health (ZL/PIH) uses an integrated, comprehensive primary care system that includes community health, quality hospital-based services, and programs aimed at the underlying social and economic causes of poverty. It has several key components:

- Community health workers (accompagnateurs) are at the heart of the ZL/PIH model. They not only conduct traditional community health activities but also make home deliveries of medications and provide social and financial support for patients with HIV and tuberculosis.
- Three referral hospitals and nine health centers provide quality primary care and specialty services.
- In partnership with local organizations, the model promotes integrated development. ZL/PIH's education, food security, shelter, and livelihood programs address root causes of poverty and illness. For example, a collaboration with the microfinance organization Fonkoze (see Livelihoods section) reaches the poorest Haitians with livelihoods training and asset transfer (e.g., the provision of chickens) to create a path out of poverty. Meanwhile, Zanmi Agrikol (Partners In Agriculture) works with local farmers to produce a peanut-based therapy for malnourished children (SEE BOX 1 ON PAGE 11).

The model is both scalable and sustainable because ZL/PIH is committed to working in partnership with the Haitian Ministry of Health to strengthen the public health system for the long term. To this end, ZL/PIH is currently building basic health infrastructure and renovating the existing clinics and hospitals. More networks of community health workers are being established and the public medical education system is being expanded at a new site in Mirebalais.

Nonprofit agent: Founded in 1987, Zanmi Lasante (ZL) ("Partners In Health" in Haitian Kreyol) has been working in Haiti for more than 20 years. Its team provides comprehensive health care to 1.2 million people living in the Central Plateau and Artibonite departments of rural Haiti. A network of community health workers, who support 12 hospitals and health centers in the region, makes this possible. With the influx of refugees from Port-au-Prince since the earthquake, ZL/PIH has been delivering care to an estimated 1.6 million Haitians in the Central Plateau and Artibonite and tens of thousands more in temporary settlements in the capital city.

Partners In Health (PIH) works to bring modern medical care to impoverished communities in 12 countries around the world. The organization has three goals: to care for patients, to alleviate the root causes of disease in communities, and to share lessons learned about the most effective strategies for change. Based in Boston, PIH employs more than 11,000 people worldwide, including doctors, nurses, and community health workers. Over 99% of PIH staff are local nationals based in the communities they serve.[9]

Impact: While a comprehensive evaluation has not yet been performed (one is currently under way of its program in Rwanda with funding from the Doris Duke Foundation), several studies have been published that assess important aspects of the ZL/PIH model.

MODELS IN PRACTICE (CONTINUED):

Findings show that:

- ZL/PIH drastically **improved access** to medical care, including HIV testing, tuberculosis diagnosis and treatment, vaccination, contraception, and prenatal care.[10]

- The organization's HIV Equity Initiative brought **HIV prevention and treatment** to the region, leading to improved HIV outcomes.

  In 1995, ZL/PIH provided the first free HIV medication in Haiti to prevent the transmission of HIV from mother to baby. This led to a drastic increase in the percentage of women getting HIV testing in pregnancy, from 30% to more than 90%, and a corresponding drop in the rate of babies infected with HIV.[11] ZL/PIH's work to increase access to HIV prevention and treatment has been cited as a major contributor to the decreasing rates of HIV in its service area. In five years, the percentage of pregnant women testing positive for HIV fell almost 50% from more than 5% to 2.8%, a significant public health achievement.[12]

  By training community health workers to help HIV and tuberculosis (TB) patients obtain medication, ZL/PIH has improved survival rates and patient outcomes. The portion of patients lost to follow-up in the HIV program was less than 6%.[13] This is an exceptional rate for very sick patients in the developing world, where the average rate of patients dropping out of medical care is often more than 15%.

- **Maternal health improved.** When ZL/PIH started working in Haiti's Central Plateau, a 1985 survey estimated maternal mortality at 1,400 deaths per 100,000 live births. In 2008, PIH estimated this rate had dropped well below 100 deaths per 100,000 live births. PIH attributes the change to strengthened public health infrastructure and trained staff, greater access to high-quality obstetrical services and prenatal care, and overall improvement in the region's primary health care system.[14]

- **ZL/PIH's community health workers (CHWs)** are a highly effective part of the health system. A 2007 study found that they were well-trained in outpatient drug administration for patients with HIV and TB. CHWs could also recognize side effects of the drugs they provided as well as symptoms of other medical conditions. The study further found that more than half of those who went to clinics for HIV testing were referred by CHWs. The study also noted that CHWs facilitate the use of clinic services by the most vulnerable households.[15]

FIGURE 3: ZL/PIH CLINIC SITES IN HAITI

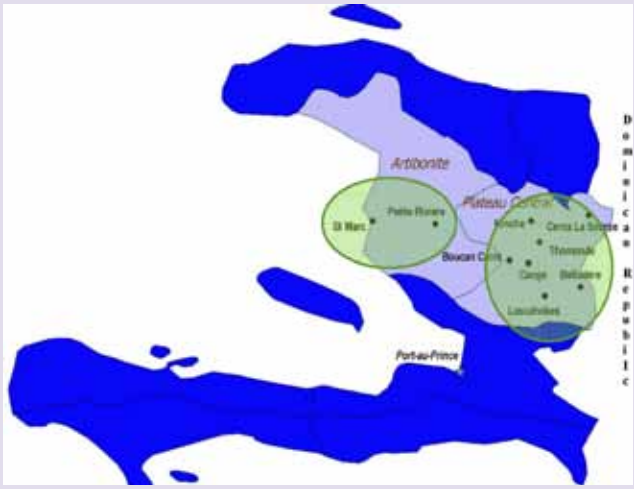


Image provided by Partners In Health

Cost/resources required: Although a full cost analysis of the Haiti program has not been performed, a cost assessment of PIH's work in Rwanda by the Clinton Foundation estimated annual costs at $28 per capita for its comprehensive system of care including medical, food support, education, and livelihoods programs.[16] In Haiti, ZL/PIH has an annual operating budget of about $25 million to provide care to a population around 1 million to 1.2 million people.[17] Our rough back-of-the-envelope calculation suggests that the costs in Haiti are comparable to those in Rwanda ($20 to $25 per capita/year). As was true for HAS's costs, these estimates compare favorably with those of the Commission on Macroeconomics and Health for an essential package of interventions in developing countries and the average per capita health spending in high-income countries.[18]

Cost per impact profile: For $20 to $25 per capita (our rough estimate), ZL/PIH has provided access to quality primary care and specialty services resulting in marked improvement in health outcomes in areas such as HIV survival and maternal health. (See impact section above for additional details.) We cannot calculate an overall cost per impact profile at this time because data on population-based estimates of health are not yet available. However, we anticipate that the study currently under way in Rwanda will provide important insight.

MODELS IN PRACTICE (CONTINUED):

How your dollars can help: Philanthropic capital is needed to both strengthen ZL/PIH's current activities as well as to support the expansion of its services to other communities in rural Haiti and to victims of the earthquake in Port-au-Prince. Responding to the needs of families displaced by the earthquake, ZL/PIH runs mobile medical clinics in four settlement areas that provide primary care services to approximately 100,000 people. To meet continuing needs in the aftermath of the earthquake, ZL/PIH staff members are expanding their surgical, mental health, and physical therapy services. Zanmi Agrikol, PIH's agricultural arm, is working to plant emergency crops and to train families in improved agricultural practices. In so doing, Zanmi Agrikol will provide both food and employment to Haitians.

Nonprofit contact: Christine Hamann at chamann@pih.org or (617) 998-8965 or visit the Partners In Health website: http://www.pih.org or its Haiti relief site: http://www.standwithhaiti.org/haiti.

BOX 1: ADDRESSING MALNUTRITION – ZANMI AGRIKOL (PARTNERS IN AGRICULTURE)

ZL/PIH works closely with Zanmi Agrikol, a program founded in 2004 that seeks to fight child malnutrition, food insecurity, and unemployment in Haiti. The program trains and employs local farmers and families to grow the ingredients needed for Nourimanba, a fortified peanut-based food supplement (also called a "Ready to Use Therapeutic Food" or RUTF) and Nourimil, a nutritious blend of cereal and legumes. Research conducted over the past 15 years demonstrates that RUTF is the most effective treatment for child malnutrition. RUTFs cost less and are more effective than hospitalization or dry food therapy.[19] Six thousand malnourished children had already been treated in a Zanmi Agrikol pilot program by mid-2009.[20] The organization aims to increase local production of this essential medicine, supporting both children and the agricultural sector in Haiti.

Zanmi Agrikol also runs a Family Assistance Program that provides agricultural training, seeds, tools, and goats to families of malnourished patients. As a result, vulnerable families can grow and sell food, leading to improved food security. Community agricultural agents (ajans agrikol) work directly with families to teach them agricultural techniques that improve the yield on their own land. Each agricultural agent is responsible for visiting ten families in their fields once every two weeks.[21]

For more information about this project, contact PIH, referencing Zanmi Agrikol.

Images provided by Partners In Health

Additional nonprofits implementing the community-based primary health care model in other regions of Haiti.

While we have not yet performed in-depth analyses of their impact, we provide the following organizations as additional options based on their reputation, international awards, and use of this evidence-based model.

Haitian Health Foundation (HHF): HHF works to improve the health and welfare of the people in the rural city of Jérémie in southwestern Haiti. HHF was founded by Dr. Jeremiah Lowney in 1982 and currently serves over 225,000 people in more than 100 rural mountain villages. HHF sponsors a variety of programs in health care, community development, education, and relief services. In 2008, its director of public health received the Global Health Council's 2008 Best Practices in Global Health award for using Health Track, a computerized health information system, to track the medical care and health status of 130,000 Haitians in more than 100 villages.[22] **http://www.haitianhealthfoundation.org**.

Promise for Haiti: Founded in 1981 as the Christian Mission of Pignon by local Haitian surgeon Dr. Guy Theodore, Promise for Haiti provides health care, education, community development, clean water, and community leadership to the communities of the Pignon region in northern Haiti. A locally elected committee of community leaders, Comité de Bienfaisance de Pignon (CBP), presides over the Hôpital Bienfaisance de Pignon and the community health and development programs. The CBP was among the 2007 nominees for the Gates Award for Global Health and was honored by the Haitian Ministry of Health in 2007 for improving health conditions.[23] **http://www.promiseforhaiti.org**.

TIPS FOR ASSESSING COMMUNITY-BASED PRIMARY HEALTHCARE PROJECTS:

To achieve the kind of results described in this guide, a community-based primary healthcare system will have:

- Preventive care and treatment services that reach people where they live. These are often delivered to households by community health workers, mobile clinics, and health educators.
- Links to a referral system including basic hospital care and essential surgery. It is the presence of this entire comprehensive system that produces results.
- Focus on capacity development of the local community through training and employing members of the area as nurses, community health workers, and staff. Organizations build the capacity of the public medical system for long term sustainability rather than acting as a parallel system through activities such as improving the infrastructure of public facilities and serving as a training site for healthcare workers.
- Track record of experience and trust working with the target population as evidenced by community feedback surveys and documented use of health services offered. Organizations use knowledge of the local health situation to select and deliver the most needed prevention and treatment (e.g., clean water, immunizations, and prenatal care).
- Partnerships and networks to address the root causes of ill health. Health systems that link to programs in literacy, improved agricultural and food security, clean water and sanitation, and income generation activities will have the greatest long-term impact.
- Feedback system to assess the quality of program implementation and evidence of its impact. Organizations do this through the use of household census, tallies of the use of key health services, and surveys of community health.

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Photo by Darcy Kiefel. Image provided by Fonkoze.

Photo by Darcy Kiefel. Image provided by Fonkoze.

OPPORTUNITY 2: LIVELIHOODS

Enabling Households to Provide for Themselves

Haiti: How Can I Help?

June 2010

Opportunity for Philanthropists

If Haiti is to move beyond the current devastation and dependence on aid, its people have to be able to make a living. In this section we highlight two models: the Graduation Model, which helps ultra-poor women move out of extreme poverty by generating a steady income, and the Sustainable Agriculture Model, which improves farmer incomes while preserving the environment. By supporting these models, you can give Haitians the opportunity to work towards a better life.

THE CONTEXT

This section focuses on ways you can help Haitians provide for themselves and their families. Job creation will be central to enabling Haitian households to move beyond the earthquake's devastation. However, given Haiti's extreme poverty, level of unemployment, widespread deforestation, and environmental degradation before the earthquake hit, any promising model will need to consider:

- *building assets for those who have nothing, and*
- *promoting environmentally sustainable ways to make a living.*

Table 1 below puts Haitian income levels and sources of livelihood in perspective.

Around the world, people's ability to provide for themselves and their families depends on five types of capital or assets:[1]

- *Human capital*, such as household members' ability to write and read or knowledge of how to raise animals, weave baskets, or grow food
- *Natural capital*, such as access to land and water
- *Financial capital*, such as earnings, savings, and access to credit and markets
- *Social capital*, such as networks of people who can help in difficult circumstances or provide guidance on important decisions
- *Physical capital*, such as farm tools or goats

Effects of the earthquake

Disasters such as an earthquake affect people's ability to provide for themselves in multiple ways. They force household members to sell off their assets in order to feed, clothe, and shelter themselves. For already poor people, this triggers a descent into extreme poverty. The earthquake has disrupted jobs, and as households earn less, families buy less, thereby contracting the local economy.

TABLE 1: COMPARING ECONOMIC INDICATORS[2]

	Haiti	Dominican Republic	United States
People living below:			
$1.25/day	55%	5%	N/A
$2/day	72%	15%	N/A
Formal sector unemployment rate[A]	> 66%[B]	15%	9%
GDP / capita (US $)	$699	$3,772	$45,592
Human Development Index[C] ranking (out of 182 countries)	149	90	13
People working in:			
Agriculture	66%	15%	<0.7%
Services	25%	63%	79%[D]

[A] *Formal sector employment is employment which has taxable income.*
[B] *CIA World Factbook estimate*
[C] *A UN measure of well being in a country*
[D] *Estimation based on data from CIA World Factbook*

In Haiti, the recent earthquake destabilized the lives of hundreds of thousands of urban residents. A great many have migrated to rural areas in search of new livelihoods. Reverse migration has added stress to an already weak rural economy, which cannot produce enough food to feed the increased population or provide enough jobs to absorb the new labor. Migrants who may have had livelihoods in Port-au-Prince must now learn new skills in order to adapt to a rural environment.

HOW YOU CAN CHANGE THE SITUATION

In this section, we discuss two models that allow families affected by the earthquake to take care of themselves for the long term:

SOLUTION 1: The Graduation Model: The first model targets the poorest of the poor, helping them to create jobs for themselves and gradually integrate into the economy.

SOLUTION 2: Sustainable Agriculture: The second model targets farmers, enabling them to grow enough food for their families, sell produce for income, and contribute to regenerating land that has been severely degraded due to deforestation and natural disasters.

To give you an idea of how the models look on the ground, our Models in Practice on the following pages give two concrete examples of nonprofits pioneering the approaches in Haiti.

SOLUTION 1: THE GRADUATION MODEL

Boosting people's income, building their assets, and increasing their participation in the economy is essential to helping people provide for their families. The graduation model does exactly this.

Unlike microfinance models which target people who have a source of income, the graduation model works with those who have no income or assets. It helps them generate a source of revenue, readying them for microfinance in the future.

A Bangladeshi nonprofit, BRAC,[3] developed this model in 2002. BRAC observed that traditional microfinance was failing to reach the poorest people and sought ways to reach them without making them permanently dependent on a social safety net program. Once BRAC established the success of this model, the Consultative Group to Assist the Poor (CGAP),[4] a policy center in Washington, D.C. that promotes financial access for the world's poor, helped to pilot the graduation model in 9 countries.

GREAT BANG FOR BUCK: THE GRADUATION MODEL

Cost per impact: ~ $1,600 per woman to move from extreme poverty to increased economic security.

Representative Impacts:

- long-term, steady source of income
- initial savings and a habit of saving
- access to adequate and diverse food
- improved health and healthcare-seeking behavior

(SEE MODEL IN PRACTICE 1 FOR SOURCES OF THIS DATA.)

MODEL IN PRACTICE 1:

The Graduation Model: Moving the ultra-poor along the pathway out of poverty

About the model: With over 50% of Haitians living on less than $1.25 a day,[5] the Graduation Model is essential to Haiti's poor. A Haitian non-profit, Fonkoze, piloted the Graduation Model in Haiti with help from CGAP. The pilot worked with 150 ultra-poor women in three zones in Haiti, for an 18-month period from 2007 – 2009.[6] Fonkoze's pilot was successful and has developed into a full-fledged program run by Fonkoze. This program is called Chemen Lavi Miyò (CLM)—or 'Pathway to a Better Life' in Haiti's Kreyol language.

CLM is an 18-month asset transfer program that provides women with productive physical assets (such as goats and chickens), skills, confidence and social networks, shelter, a cash stipend, and access to healthcare. As a result, clients "graduate" to income-earning activities that enable them to sustain themselves without external subsidies.

Nonprofit agent: Fonkoze, which is short for Fondasyon Kole Zepòl or 'Shoulder to Shoulder Foundation' in Haitian Kreyol, was founded in 1994 and is Haiti's largest nonprofit microfinance institution. Fonkoze serves 45,000 loan clients and 200,000 savings clients through 41 branches across Haiti. It provides its clients with loans, a savings facility, skills to improve assets and generate income, access to free clinics, and education programs.

Fonkoze has been able to adapt the Graduation Model to make it suitable for women in Haiti.

Who it targets: CLM targets extremely poor rural women—those without productive assets who often do not have enough to eat—in especially impoverished parts of Haiti.[7] These are women who are capable of and willing to work, but have no jobs or assets, no reliable access to food, and often no housing. At the same time, they often have large families to support and children who are out of school. Usually illiterate, these ultra-poor women have minimal income-generating skills. Yet a large body of evidence indicates that investments in such women can be a powerful lever for lasting, sustainable impact in the poorest communities.[8]

> CLM is not a microfinance program. It helps those with no income create a source of income. It enables the poorest of the poor to gradually increase their income and assets until they are eligible for traditional microfinance.

How it works: CLM provides ultra-poor women with appropriate support to enable them to advance to progressive levels of economic independence.

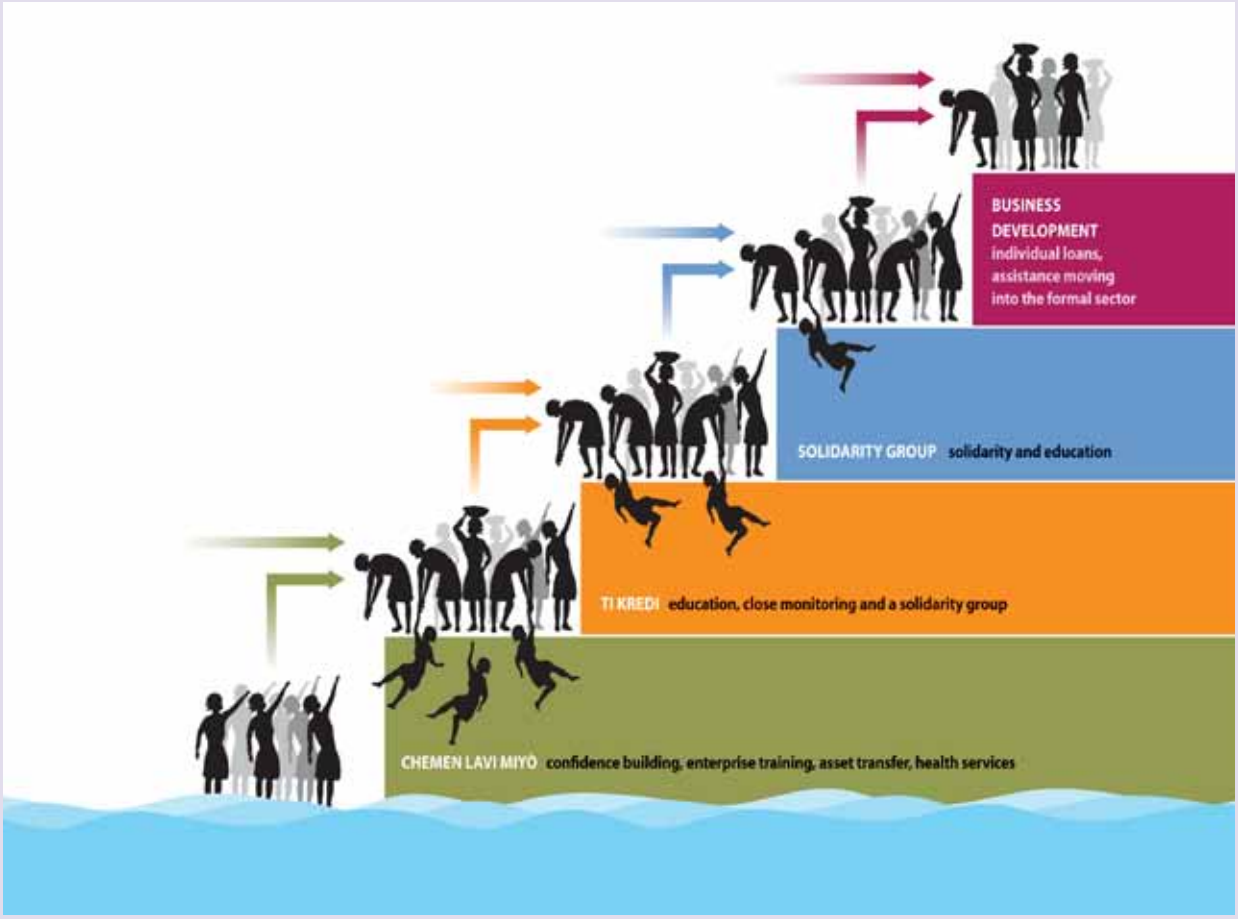
Figure 1 (page 18) describes the four programs that Fonkoze runs for people at different levels of poverty. In this guide, we focus on CLM, which targets women on the bottom step of the staircase. Figure 2 (page 19) describes the steps in CLM. As microfinance becomes increasingly commercial, this bottom step is where philanthropic capital can have the greatest impact.

Fonkoze identifies participants through a comprehensive, three-stage process to ensure it reaches the truly ultra poor whom traditional microfinance cannot help.[9]

Photo by Darcy Kiefel. Image provided by Fonkoze.

MODEL IN PRACTICE 1 (CONTINUED):

FIGURE 1: FONKOZE'S STAIRCASE OUT OF POVERTY



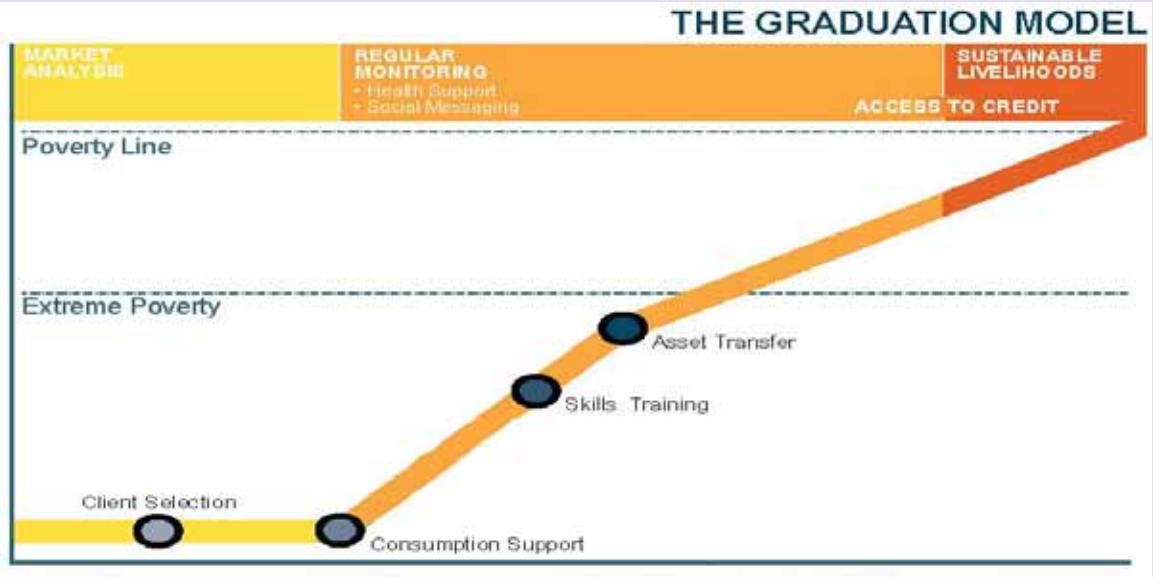
Source: Used with permission from Fonkoze.

Once participants, or members, are identified, they are assigned a case manager. Over a period of 18 months, that case manager interacts intensively and individually with 50 members, visiting their homes once a week and providing each with assets, training, and a stipend. The program has three key components:[10]

- Asset transfer: The program provides two, income-generating assets to each member. These can include a goat, chickens, or goods such as cosmetics or plastic ware that members can sell. It provides materials for constructing a 9 x 9 meter home comprised of a tin roof and concrete floor, a toilet, and a water filter. Since members at this stage have no income, the program also provides a $180 stipend over six months.
- Skills training and health resources: Members are taught a variety of skills ranging from enterprise management to life skills. Enterprise training teaches the women how to sell goods, rear animals (e.g., goats or chickens), and manage income. Life skills training teaches literacy, health (e.g., the importance of clean water, how to use birth control) and childrearing (e.g., how to prepare and feed healthy food to children). Through partnerships with providers like Partners In Health, the program gives members access to primary care, immunizations for members and their children, and other healthcare services critical to bringing women and their families out of poverty.

MODEL IN PRACTICE 1 (CONTINUED):

FIGURE 2: CGAP'S GRADUATION MODEL



Source: Adapted and used with permission from CGAP

- Self-esteem and social networks: Most members are marginalized women with minimal social support systems. Village Assistance Committees address the lack of social support by bringing together influential men and women to support CLM members.[11] The village committees build the self-esteem of a member, giving her the feeling that she is worth listening to and can take control of her life. The committees also create a sense of responsibility among the more socially privileged toward the less privileged. For example, committee members will advocate on behalf of a CLM member if she is harassed by her landlord. In our view, this is a first step towards the sense of mutual responsibility that has been central to the success of group microcredit programs.

A critical factor when implementing this model, or any model targeting job creation, is to ensure there is enough local demand for the products and services that members are trained to produce. There is a limit to the quantity of baskets, eggs, or goat meat that will be purchased in a given community. Realizing the importance of diversifying jobs within a local economy, Fonkoze is seeking to offer a greater variety of productive assets and skills while expanding CLM.[12]

Another critical challenge is building partnerships with organizations which work in health, education and veterinary services.[13] As CLM expands, Fonkoze continues to build strong partnerships, including with organizations that implement models profiled in the other sections of this guide.

Impact: In Fonkoze's pilot, 95% of CLM members met graduation criteria by showing progress in the six key areas over the 18-month course of the program:[14]

- Food is on the member's table every day
- Her shelter includes a tin roof, cement floor, and sanitary latrine
- Her school-aged children are in school
- She can read and write her name
- Her business assets (e.g. goats, chicken) have grown
- She expresses confidence in facing her future

Graduating members have the skills and resources to sustainably provide for the needs of their families and the capacity to manage future economic shocks. Should they so choose, they are ready to receive their first microfinance loan.[15]

Fonkoze measures impact by using a simple, internationally recognized poverty evaluation survey called the Poverty Scorecard. A member's initial answers are compared with answers at the middle and end of CLM. A Fonkoze staff member confirms the validity of a member's answers through an in-person meeting and visit to the home.[16]

MODEL IN PRACTICE 1 (CONTINUED):

Fonkoze's internal evaluations and two external evaluations conducted by Concern Worldwide and CGAP midway through the program and 6 months after the program showed that the Graduation Model can be successful in Haiti:

- Participants significantly improved their poverty scores halfway into the program, with the average participant doubling their score—significantly reducing their poverty level.[17]
- CLM participants' incomes increased, indicated by a 20 percentage point reduction in participants living on less than $1 per day and a 10 percentage point reduction in participants living on less than $2 per day.[18] Members, almost all of whom initially had no savings, also increased their financial assets, making regular deposits into their savings accounts.[19] We think this is significant as it shows that members have acquired the habit of saving and building up their assets.
- Additionally, participants' food security increased, with more than 85% of participants reporting that their household did not lack food over the pilot period and only 6% reporting that someone in their household lost weight due to hunger in that time.[20] At the beginning of the program, all participants were food insecure and experiencing days of hunger; there were high levels of child malnutrition; and many were begging for food.[21]
- Members' health also improved, with significant reduction in gastro-intestinal diseases and an increase in health seeking behavior.[22]
- Finally, members believed they had moved out of extreme poverty and showed increased self-confidence: 99% of members reported that they had moved up on the poverty scale.[23]

Photo by Darcy Kiefel. Image provided by Fonkoze.

FIGURE 3: CLM POVERTY SCORES AT BASELINE AND AT MIDTERM

Source: Huda, K., & Simanowitz, A. (2009). A graduation pathway for Haiti's poorest: Lessons learnt from Fonkoze. Enterprise Development and Microfinance, 20(2), 86-106. Retrieved March 2, 2010, from http://www.themastercardfoundation.org/pdfs/BDI%20Lessons%20Learnt.pdf

MODEL IN PRACTICE 1 (CONTINUED):

These results are comparable to results obtained by the BRAC model in Bangladesh, of which Fonkoze's CLM is an adaptation. In its initial round of implementing the program in 2004, BRAC defined graduation as the ability and willingness to take on a microfinance loan. BRAC found that 69% of participants took out a loan at least once and 56% took out loans more than once.[24] Similarly, 80% of Fonkoze CLM members have taken out a microfinance loan at least once after graduation.[25] In subsequent rounds of implementing the program, BRAC has broadened its definition of graduation to include criteria similar to Fonkoze's graduation criteria.

Of the 95% who graduated from Fonkoze's CLM in 2009, 75% immediately took their first loan.[26] Within five months, an additional 5% took on a loan.[27] Loans are given out through Ti Kredi, the next level of Fonkoze's staircase of programs. Ti Kredi, meaning 'Little Credit' in Kreyol, is a program that provides clients a small amount of credit ($25 to $62) over six months in order to teach them to productively invest money and adhere to the discipline of repayment.[28]

Studies have found that members who move on to Ti Kredi are best able to capitalize on the gains they have made through participating in CLM.[29]

Other graduates of CLM simply stayed in Fonkoze's savings programs. Of the 5% who failed to graduate, all continued to receive CLM services for three additional months. In the end, only three women out of 150 were unable to graduate.[30]

These studies indicated that multiple aspects of members' lives improved over the course of the program. As expected there was some decline when the program ended but the members continued to eat better, generate income, build savings and other assets and continue to send their children to school.[31] An evaluation of the BRAC 2002 pilot's long term results show that participants are able to maintain their gains from the program in the long term.[32]

Fonkoze is following up with past CLM participants to understand the program's long-term impact. BRAC's results lead us to believe that this model brings long-term positive and sustainable change. A follow-up assessment of BRAC's clients two years after they completed the ultra-poor program showed that they were eating more diverse foods, which implies that food security had increased.[33] The same evaluation also showed that 55% of clients remained out of extreme poverty despite economic and natural shocks.[34]

Photo by Darcy Kiefel. Image provided by Fonkoze.

Costs/resources required: Fonkoze's CLM model currently costs $1,490 per participant and lasts 18 months.[35] See the chart on page 22 for a breakdown of costs.

The cost of implementing the program in Haiti is higher than in other places for several reasons. For instance, there are higher operating costs due to Haiti's mountainous terrain and lack of roads and other infrastructure. In addition, Haiti's relatively high cost of living increases the cost of the assets Fonkoze provides its members.[36]

MODEL IN PRACTICE 1 (CONTINUED):

TABLE 2: BREAKDOWN OF COSTS PER MEMBER FOR CLM[35]

Item	Cost (US $)
Services to members	
Assets for two livelihoods	150
Income replacement stipend over 6 months	180
Home repair	251
Water filter	22
Emergency services	40
Training expenses	78
Case management services	332
Management and support staff salaries and benefits	208
Other operating expenses	94
Subtotal	1,355
Overhead - 10%	135
Grand Total	**1,490**

Cost per impact: We estimate that it costs $1,563 to move a participant out of extreme poverty to where she can meet the needs of her household without relying on external subsidies. As the 18-month program pilot successfully graduated 95% of participants (or 143 women), this figure was arrived at by dividing the total cost for 150 participants by 143.[37] (SEE TABLE 2 ABOVE.)

How your dollars can help: The earthquake has increased the number of people who would greatly benefit from a program like Fonkoze's CLM. This is especially true because so many people have migrated out of the hardest hit areas and have very little left. Donations are especially important as Fonkoze begins to expand its program to meet this need and continues to adapt it to Haiti's context.

For more information: contact Leigh Carter, executive director of Fonkoze USA, at (202) 628-9033 or lcarter@fonkoze.org. Visit the Fonkoze website at http://www.fonkoze.org.

Photo by Darcy Kiefel. Image provided by Fonkoze.

SOLUTION 2: SUSTAINABLE AGRICULTURE

Agriculture impacts income, the environment, and availability of food. While the primary means of livelihood in Haiti is agriculture, this sector contributes to only 28% of Haiti's GDP.[38] High levels of deforestation have significantly degraded the land,[39] leading to low crop yields and increased floods and mudslides.

The Sustainable Agriculture model promotes agricultural practices that help farmers increase their income and obtain adequate food while at the same time improving soil and replanting land with trees. The trees provide fruit and therefore long-term income, and the agricultural practices promote soil and water conservation. The model pays special attention to soil and water use to preserve the whole water system and maintain a balanced ecosystem.

GREAT BANG FOR BUCK: SUSTAINABLE AGRICULTURE

Average cost: ~$90 per farmer/year increases income and regenerates deforested soil.

Representative Impacts:

- short-term: more food to eat and sell due to increased crop yields of 20% to 90%
- mid-term: farmers' return on investment goes up by 30% to 50%
- long-term: family assets increase by 110%; mudslide and flood damage mitigated

(SEE MODEL IN PRACTICE 2 FOR SOURCES OF THIS DATA.)

MODEL IN PRACTICE 2:

Sustainable Agriculture: Creating income, protecting the environment

About the model: With only 4% of Haiti under forest cover[40] and consequently much topsoil eroding, Haitian land produces few crops and natural disasters cause significant flooding and mudslides. However, high population density and poverty make it difficult to give reforestation priority over agriculture. The solution: planting fruit trees that provide food, forest cover, and a source of income.

Catholic Relief Services (CRS) began a four-year pilot program in 2009 to teach 6,000 farmers the best practices for growing fruit trees and crops and for expanding their agro-businesses. The model has successfully integrated short-term disaster relief with longer-term income generation and environmental sustainability.[41] Additional funding could bring these results to other communities.

Nonprofit agent: CRS is a US-based international development organization that serves impoverished populations regardless of faith or political affiliation. It has been working in Haiti for over 50 years and in the Haitian agricultural sector for more than 10 years. CRS has been working internationally in the agricultural sector for more than 40 years. It focuses on agriculture to promote health, to sustain the environment, to increase income, and to respond to emergencies.[42] The model it uses in Haiti incorporates each of these elements.

In implementing this model in Haiti, CRS works closely with its partner, Caritas Haiti, and Organization for Rehabilitation of the Environment, a nonprofit organization in Haiti.

MODEL IN PRACTICE 2 (CONTINUED):

Who it targets: CRS is currently implementing a pilot program that targets 6,000 farming families who do not have adequate or diverse food for any part of the year. Auxiliary programs target out-of-school youth and local seed traders.

The model also targets degraded, unproductive soil. Currently, CRS is implementing its programs in the Les Anglais, Tiburon, and Chardonnieres watershed areas.

How it works: This model of sustainable agriculture combines agro-forestry and farmer associations to increase farmers' incomes and improve vulnerable land. In times of emergency, CRS conducts seed fairs in parallel with its ongoing sustainable agriculture program to ensure that farmers have seeds for planting and that the local seed market is resilient. These components are described below:[43]

- Agro-Forestry combines tree planting and crop growing to increase incomes and improve land:
  - Planting dual-purpose trees: CRS provides farmers with saplings of resilient and fast-growing fruit trees, such as mango and papaya. These trees serve two purposes. First, they produce fruit that can be exported within four to five years and provide long-term income for the farmer. Second, they improve the land and environment by holding topsoil and water, thus preventing erosion and mudslides.
  - Growing staple crops: This is the mainstay of the model. Farmers are taught to grow short-term crops, such as corn, cassava, hot peppers, and other vegetables, between the trees. They are taught environmentally-friendly techniques to increase their crop yields. These crops are harvested every year or every few months, providing short-term income as well as food.
- Farmer Associations: These are legal associations, each of about 100 farmers, who grow similar crops. The associations help farmers expand their agricultural enterprises by training them in business development, facilitating savings and intra-group lending, and connecting the group with seed and fertilizer suppliers, traders, and exporters. The associations aggregate demand for seeds and fertilizers and aggregate produce, increasing the bargaining power of their farmer-members.
- Youth club nurseries: CRS teaches groups of young people to build tree nurseries by growing saplings and selling them to farmers. Young people develop a source of income and a sense of community.
- Seed fairs as emergency response: When natural or man-made disasters occur, farming families who may not have enough to eat often resort to consuming the seeds that they had previously harvested and stored for the next planting season. When planting season arrives, they have no seeds to plant. In such times—the months after the recent earthquake are an example—CRS holds market fairs. Here farmers, using vouchers given to them by CRS, can buy seeds from local seed traders. Traders can, in turn, exchange the vouchers for cash from CRS. This gives farmers a choice of seeds (often seeds are given away by NGOs, which means farmers cannot choose what to grow), injects cash directly into the local economy, and maintains the local seed market. (Rather than being obtained from local traders, seeds are often brought in from outside Haiti which can weaken local markets.)[44]

Photo by David Snyder. Image provided by Catholic Relief Services.

MODEL IN PRACTICE 2 (CONTINUED):

Impact: Since CRS began its new sustainable agriculture program in Haiti just last year, it is too early to have impact evaluations. However, evaluations of similar CRS-led programs in other parts of the world suggest the potential impact of the program in Haiti. Farmers who participate in these programs increase the yields and value of their crop, are more food secure, and begin to practice environmentally sustainable agriculture.

Impact data are drawn from two programs. The first program in Malawi distributed seeds and taught farmers environmentally sustainable best practices to increase crop yields. This program was led by CRS and implemented by a consortium of local and international NGOs. The second is a CRS program in Tanzania that formed farmer associations to increase income by collectively buying seeds and selling harvests.

- **86% of farmers adopted best agricultural practices**: In a program headed by CRS in Malawi, farmers were given seeds and taught best practices in farming, such as rotating crops and using manure for compost. The final evaluation showed that 86% of participating farmers adopted at least three or more best practices.[45] The program was so successful that non-participating farmers also began to adopt these practices. Moreover, since farmers were able to obtain a wider variety of seeds through this program, they were able to grow a greater variety of crops, which helps replenish soil and diversify sources of income.[46]

- **Crop yields increased significantly**: In Malawi, farmers who followed CRS best practices harvested more seeds than farmers who did not follow these practices. Farmers grew maize, peanuts, and sugar beans. The harvest size depended on the type of irrigation the farmer could provide. Harvests of maize and sugar beans grown on artificially irrigated land were 19% and 91% greater, respectively. Peanuts and sugar beans that grew on rain-fed land yielded 63% and 26% more seeds.[47]

- **Participating farmers sold crops for 22% more than non-participating farmers**: Measuring the monetary value of different harvests is a good proxy for measuring differences in household income. Participating farmers in the CRS-headed Malawi program realized an average 22% increase in value of crops compared to farmers who did not participate.[48] Their crop production was higher, and they were able to negotiate a better price because they were selling their crops collectively.[49]

- **Increased food security**: As crop yields and incomes increased, farmers gained access to more produce and purchased more foods, thereby significantly increasing their family's food security.[50]

- **Value of farmer family assets increased by 111%**: The value of household assets represents the household's physical capital and indicates how vulnerable families are in times of crisis. CRS found that participants in the Malawian program more than doubled the value of their livestock assets, domestic assets such as beds or stoves, and production assets such as farm tools. With a 111% increase,[51] the participants significantly augmented their physical capital and decreased their vulnerability.

- **Farmers increased their return on investment by 30% to 53%**: In Tanzania, farmer associations sold crops grown by member-farmers for 20% more than the price that traders were offering individual farmers.[52] Interacting regularly in an organized manner also helped farmers become better informed about the market and about how to evaluate their costs of production. Both of these are essential for negotiating prices with traders. Member-farmers increased the returns on their investment by 30% to 53%.[53]

These results are particularly impressive given the following common challenge: Programs focused on agriculture often target vulnerable farmers who till small plots of land they do not own and may not till again. Convincing them to consider the long-term benefit of improving soil is difficult. In the program it led in Malawi, CRS found that allowing farmers to make decisions about what to grow or when to conduct training led to increased interest, greater participation, and a more successful program. Farmers began to feel that they had personal stakes in the program and began to consider long-term issues.[54] CRS plans to use the same methods in Haiti to convince more farmers to participate in its program.

Cost/resources required: The program in Haiti costs $87 per beneficiary per year.[55]

MODEL IN PRACTICE 2 (CONTINUED):

Cost-impact profile: For an average cost of $87 per farmer/year in Haiti, data from Malawi and Tanzania suggest the potential for the following increases in income, food security, and better farmland.

- **Income**: crop yields increase by 19% to 91%; harvests sell for 22% more; farmers' returns on investment increase by 30% to 53%; and subsequently their household assets double in value.
- **Food security**: As crop yields and incomes increase, families have access to a greater quantity and variety of food.
- **Sustainable agriculture**: 86% of targeted farmers adopt best agricultural practices.

How your dollars can help: Supporting sustainable agriculture is both essential and smart for three reasons: two-thirds of the Haitian population is engaged in agriculture, the earthquake has caused Haitians to migrate to rural areas, and Haitian soil is degraded. Donations will help CRS extend its program to regenerate more land and improve the livelihoods of farmer families for now and for the future.

Nonprofit contact: Jim Lund, vice president for Charitable Giving and Awareness, CRS at (410) 234-3135 or jlund@crs.org. Visit the CRS website at http://crs.org.

TIPS FOR ASSESSING LIVELIHOOD PROMOTION PROJECTS:

In this section we focus on two models that promote the livelihoods of the poor. This guide provides two concrete examples of the models being put into practice by nonprofits, but there are many other effective organiations in Haiti and throughout the world that implement these evidence-informed models. Trickle Up and SKS are among a number of organizations mentioned on page 41 that are implementing the Graduation Model internationally.

For more information on the graduation and sustainable agriculture models, please see our website: **http://www.impact.upenn.edu**. If you are interested in supporting the graduation or sustainable agriculture model that promotes livelihoods, here is what to look for:

- *Strengthen local economies.* The poor can earn an income only if local markets support their goods and services. Look for models that make local economies grow rather than shrink. For example, the seed fairs, described in the Sustainable Agriculture model, consciously seek to promote sales of local seeds by local farmers, instead of importing seeds from outside the area or country. This keeps cash circulating within the local economy, promoting its growth.
- *Increase people's income.* There are many ways to increase income: by increasing productivity, aggregating demand and products, or decreasing expenditure. Check to see how a model does any or all of these things. For example, grouping bamboo basket weavers together aggregates their demand for bamboo, which means they can buy cheaply at wholesale prices. Fair trade practices aim to increase income.
- *Look beyond financial capital.* People's ability to support themselves and their families depends not only on their financial capital, but also on their skills, their networks, and their tools. Page 15 describes this concept in further detail. While microfinance provides financial capital, there are many other services that can complement a microfinance loan and allow people to better leverage it. Without these other services, microfinance will not always be successful in moving people out of poverty.

TIPS FOR ASSESSING LIVELIHOOD PROMOTION PROJECTS (CONTINUED):

- *Increase people's assets*. Assets are as important as income. Productive assets like farm tools, goats, or a weaving loom increase the ability of people to generate an income. Non-productive assets like shelter mitigate risks and improve the ability of people to recover from economic shocks. Consider supporting models that develop people's existing assets—assets people already know how to use—since those are assets that will be best utilized. In models that distribute assets, check that there are enough different types of assets being given out so that the value of one asset does not collapse. For example, if all participants of a program are being given goats, the price of goat milk and meat will decrease.
- *Promote productive agriculture*. Make sure the model promotes farming practices that conserve soil and water, considering both upstream and downstream effects of soil and water usage.

Photo by David Snyder. Image provided by Catholic Relief Services.

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[3] BRAC is a large Bangladeshi development organization founded in 1972 and working on long term sustainable poverty reduction: http://www.brac.net/index.php

[4] CGAP is an independent policy and research center housed at the World Bank dedicated to advancing financial access for the world's poor: http://www.cgap.org/p/site/c/home/

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[9] First, the members of the village identify those households the community considers to be the poorest. Fonkoze's staff visits their homes and administers a simple, internationally recognized poverty evaluation survey called the Poverty Scorecard and an equally simple food security survey. The surveys measure housing quality, food security, asset value, literacy, sources of income, school attendance of school-age children and business expenditures. Finally staff visits each potential participant a second time to confirm that they are indeed the poorest of the poor. Fonkoze's Poverty Scorecard is based on the Progress out of Poverty Index and integrates poverty indicators developed for Haiti by the Grameen Foundation.

[10] See reference 6.

[11] Personal communication with Natalie Domond, director of social performance management and market research at Fonkoze Foundation, Haiti, February 27, 2010 and April 13, 2010.

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[47] See Reference 46.

[48] Ibid.

[49] Ibid.

[50] See Reference 46; Personal communication with Geraldine Brick, technical advisor for food security, CRS, April 12, 2010.

[51] See Reference 46.

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Image provided by Save the Children

Photo by Melissa Winkler. Image provided by International Rescue Committee

Photo by Melissa Winkler. Image provided by International Rescue Committee

OPPORTUNITY 3: EDUCATION

Addressing the Education Needs of Haiti's Children

Opportunity for Philanthropists

There can be no lasting improvements in Haiti without educating Haiti's children. This section describes two models to bring education to the more than one million Haitian children who currently have no access to schools. The first model is Community Schools, a proven strategy to increase educational access for poor, rural children. The second model is Healing-Focused Emergency Education. Emergency education with a special focus on jump-starting the healing process is a tested approach to providing immediate access to education for children traumatized by war or disasters. Both models are examples of opportunities for effective investments in Haiti's long-term development.

THE CONTEXT

Education is fundamental to improvements in health, political stability, and the capacity for people to earn a living and take care of their families.[1] Worldwide, there is a direct connection between lack of education and poverty.[2] This is especially true in Haiti where, even before the earthquake, only 50% of school-age children (ages 7-12) attended school and 90% of uneducated people lived below the poverty line.[3] The consequences of a lack of education tend to be particularly severe in Haiti because high unemployment makes competition for jobs especially fierce.

Before the earthquake, Haiti had a limited public education system with only 10% of schools operated by the government.[7] The majority of schools were operated by private sector for-profit and nonprofit organizations. The quality of education varied greatly because the government lacked the capacity to provide quality control. For most families, the best private schools were financially out of reach. Most could not afford the required school fees. In addition, for rural families, both private and public schools were often physically out of reach as many children could not walk the long distances required to attend school.

TABLE 1: COMPARING EDUCATION INDICATORS[4]

	Haiti	Dominican Republic	United States
Adult literacy rate	62%	89%	99%
Primary school enrollment	50%	89%	92%
Child labor	21%	10%	0.2%

Earthquake Impact in Haiti:

- 87% schools in Port-au-Prince (8000 schools), 96% in Leogane, and 88% in Jacmel were damaged or destroyed[5]
- 2.9 million children not able to go to school[6]

HOW YOU CAN CHANGE THE SITUATION

Right now, the critical need is to increase access to quality education, including maximizing students' opportunity to learn. In this section, we discuss two effective models. Both address the immediate need for access, can deliver high quality education, and work concurrently to strengthen the capacity of the public system to sustain impact. To give you an idea of how these models look on the ground, we provide two examples from nonprofits that were instrumental in their development.

SOLUTION 1: Community Schools: The first model is designed to enable poor, rural communities to establish schools near children's homes to increase the number of school-age children with access to education. There are several organizations implementing and supporting community schools in Haiti and around the world. In our Model in Practice on the following page, we provide details on how one nonprofit, Save the Children, has been implementing this model effectively in Haiti.

SOLUTION 2: Emergency Education Focusing on the Healing Process: The second model addresses the needs of children who have experienced extreme trauma, such as that caused by the Haitian earthquake. It provides teachers with the specialized training to meet both the educational and psychosocial needs of students. Several organizations specialize in emergency education. One international nonprofit, the International Rescue Committee, has developed an emergency education program called Healing Classrooms, which the organization has successfully introduced elsewhere and has already begun implementing in Haiti.

SOLUTION 1: COMMUNITY SCHOOLS

The Community Schools model was developed in the early 1990s to increase village children's access to schools. The model seeks to increase local capacity so communities can play the primary role in providing appropriate and relevant education to their own children. The Community Schools model has been put into practice by several organizations in a number of countries, including Afghanistan, Angola, Colombia, Ethiopia, Guatemala, Mali, Nepal, and Uganda. The core elements of the model are:[8]

- Locating new schools in or near communities where children live.
- Training community management committees that are responsible for the administration, supervision, and management of the schools.
- Recruiting and training local teachers who can teach in the local language and are responsive to the needs of rural students.
- Creating locally relevant curricula and school calendars. These are set by the community and take into account daily life and relevant economic opportunities in rural areas.
- Providing technical support, materials, and training for the school committees and teachers with the help of nonprofit advisors.

These core components overcome many of the barriers that rural children face in gaining access to education: schools that are physically out of reach, unaffordable school fees, and high teacher turnover. This last factor has a negative effect on student learning in developing countries as well as in the United States.[9,10]

GREAT BANG FOR BUCK: COMMUNITY SCHOOLS

Cost per impact: $1,320 gives a rural Haitian child the opportunity to finish school through the 3rd grade with basic reading ability, a significant impact in a country where half the children are not in school and only 62% of adults are literate. (SEE MODEL IN PRACTICE 1 FOR SOURCES OF THIS DATA.)

MODEL IN PRACTICE 1:

Community Schools: Giving Rural Haitian Children the Opportunity to Learn

About the model: In 1992, Save the Children launched a community schools program in Mali, and in 1999 the organization introduced a similar program in Haiti. It has since set up 30 community schools in the rural mountainous region of Maissade, while also providing teacher training, supervision, supplies, and health and nutrition aid to the 10 government schools and 14 private schools in the region.

Nonprofit agent: Founded in 1932 to mitigate the effects of the Great Depression on children in Appalachia, Save the Children USA is now one of the largest children's advocacy organizations in the world, serving more than 48 million children in 50 countries. The organization works in the United States and abroad across the many sectors that affect children's lives, including health, education, livelihoods, and emergency response. It has been working in Haiti since 1978, running programs that address education, child protection, health, nutrition, and food security.

Impact: When you look at efforts to improve education in the developing world, three indicators matter:

- The first is access: Are there schools located within a reasonable distance of the target population? If there are fees, can households afford them?
- The second is completion: Do the students attend regularly and finish the primary cycle?
- The third is learning: Are the educational interventions provided by the schools leading to results?

Evidence from the community schools initiative in Mali demonstrates the model's success along all three metrics.[11] Over 10 years, total enrollment rates in the targeted region in Mali rose to 62% from 27%, primarily due to the growth of community schools during that period, not to the growth of government schools. In fact, in villages with community schools, the enrollment rate had already reached 96%.[12] In 2006, primary school completion rates at community schools were 67%, which is better than the 56% completion rate in the government schools and a significant achievement in a region where most children previously did not attend school or were pulled out of school to participate in farming.[13] Finally, a study found the 2003 national exam pass rate for sixth graders in the community schools was 51%, compared with 43% in the government schools.[14]

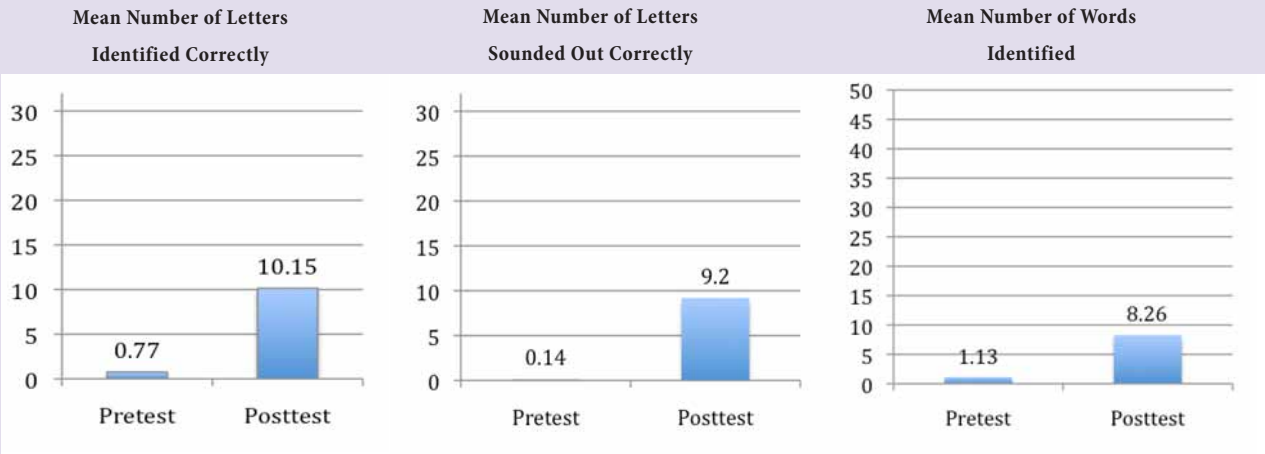
In addition, community schools in Mali served to strengthen the public education system because many of the community schools ultimately were incorporated into the public system. Rather than take resources away from the government, the initiative helped decentralize Mali's Ministry of Education and diversify the national system.[15]

In Haiti, the community schools initiative in the Maissade region has shown similar gains and important insights for adapting the model in Haiti:

- Access: Between 1999 and 2006, the number of children enrolled in community schools quadrupled, from 1,048 to 4,185.[16] Part of this success is undoubtedly due to location. In general, government schools are clustered around the main town of Maissade, whereas the community schools are farther from town, making them more easily accessible to children living in remote villages.
- Completion: As of this writing (June 2010), we did not have official primary school completion rates for Maissade. In 2007, a school effectiveness study found that community schools had a third grade completion rate of 37% and the government schools had a rate of 32%.[17]
- Learning: The study mentioned above found that in the top three community schools in the sample, the percentage of third-graders with basic reading fluency ranged from 70% to 90%, while the rate for third-graders in the highest performing government school in the survey was 70%.[18] However, performance among community schools varied. To address widespread deficiencies in reading, Save the Children launched Lekti Se Lavni (Reading is the Future), a systematic, evidence-based method for improving Haitian children's literacy skills in their native Haitian Kreyol. The data in Figure 1 on the following page demonstrate the immediate impact that the Lekti Se Lavni program has had on developing fundamental reading skills after just a four-month pilot period.[19]

MODEL IN PRACTICE 1 (CONTINUED):

FIGURE 1: 4-MONTH RESULTS OF "READING IS THE FUTURE" PILOT[19]



Prior to the earthquake in January 2010, Save the Children was working with the Ministry of Education to gain official approval for the Lekti Se Lavni curriculum—a first step in taking the program to scale. In addition, the nonprofit was exploring ways to complement classroom learning through reinforcing activities outside of the classroom such as developing children's reading materials, parent workshops to raise awareness of the importance of reading to children, reading camps, etc.

Cost and cost effectiveness: In Maissade, Haiti, the average cost per student, per year in a community school is $54; the average annual cost per student for a government school is $77.[20] It is estimated that community schools in Haiti operate at about 70% of the cost of the government schools, and the startup costs are much lower than for government schools due to community involvement in the construction, maintenance, and upkeep of the schools, and the recruitment of teachers from the villages rather than from the cities.[21]

The 2007 study previously mentioned found that community schools on the whole were more cost-effective than government schools in producing students who complete the third grade and were able to read at a rate of at least 30 words/minute (an indicator of basic reading ability).[22] (SEE TABLE 2 BELOW.)

How your dollars can help: While one of the strengths of community schools is that they recruit teachers from the local villages, this also means the teachers need more training to provide high quality education. The salaries paid by the government and the community management committees are often so low that teachers leave in search of higher-paying jobs. By funding programs that train teachers, increase salaries, and provide technical support to existing schools, philanthropists can leverage previous successes, improve educational quality, and create lasting impact. In addition, funds can be used to reduce school fees which can increase enrollment among students who currently can not afford them.

Nonprofit contact: Tim Rogers at trogers@savechildren.org, (203) 221-4242, or visit the Save the Children website: http://www.savethechildren.org.

TABLE 2: COST EFFECTIVENESS OF COMMUNITY SCHOOLS[22]

	% 3rd graders completing	cost/ completer	% 3rd graders with basic reading fluency	cost/3rd grader with basic reading fluency
Community Schools	37%	$437	33%	$1,317

SOLUTION 2: EMERGENCY EDUCATION FOCUSING ON THE HEALING PROCESS

In emergency situations, such as post-conflict or post-natural disasters, children are especially vulnerable. In the immediate period following emergencies, the physical safety and psychological health of children are paramount. Aside from the physical risks, children tend to suffer more psychological trauma than adults and are often just as frightened by the reactions of the adults as they are by the actual events they have witnessed. If not properly dealt with, this psychological trauma can have adverse effects throughout their lives, impacting their families and communities.

Emergency education ensures the safety of children while facilitating the healing process. The best emergency education model is one that pays special attention to the psychological needs of children. It provides specialized training for teachers and caregivers on how best to attend to both the educational and psychosocial needs of students affected by conflict or disasters. It uses this focus on healing throughout the following phases:

1. Establishing child-friendly spaces: These are areas that are monitored for safety. In such spaces, children regain a sense of normalcy through play that can involve sports, art, or other activities. Activities are often tailored to the local culture. For example, in Haiti, singing has played a key role in bringing a sense of normalcy and beginning the healing process.

2. Setting up temporary schools: This requires conducting an assessment to determine how many schools are needed and where, how many teachers need to be trained to replace teachers who have died, and how many additional teachers are needed to improve access to education. Since teachers play a critical role in creating environments where children can learn and heal, teacher training includes how to address the psychosocial needs of traumatized children. The model incorporates minimum standards for emergency education as developed by the Inter-Agency Network for Education in Emergencies (INEE).[23] A key to the success of both temporary and permanent schools is the involvement of community members at the outset. Often, adult members of affected communities participate in the physical rebuilding of the schools or decide on a learning space, nominate and train teachers from among local community members, and in some situations provide teachers with salaries, food, or housing.

3. Establishing permanent schools: This phase often involves working with the government and local partners to take advantage of the post-disaster environment to build back better, improving both the access to and quality of education. It also involves continuing professional development for teachers and staff and the building of more permanent structures and systems that focus on providing quality education. As with the creation of temporary schools, local ownership and input are the keys to success.

GREAT BANG FOR BUCK: HEALING-FOCUSED EMERGENCY EDUCATION

Average cost: $75 per student/year to create child-friendly spaces that jump-start the healing process, assist in the transition to more formal schooling, and improve teaching and student learning.

(SEE MODEL IN PRACTICE 2 FOR SOURCES OF THIS DATA.)

MODEL IN PRACTICE 2

Healing Classrooms: Putting Teachers and Students on the Road to Recovery

About the model: Healing Classrooms is a specialized approach to educating children in emergency situations. Developed over 27 years in conflict-affected countries, Healing Classrooms is a tested model that jump-starts the healing process by providing children immediate access to educational activities with teachers that are trained to address their psychological needs. The Healing Classrooms approach has been incorporated into most of the International Rescue Committee's (IRC) educational programs in countries including Russia, Afghanistan, Pakistan, Ethiopia, and Liberia.

Nonprofit agent: Founded in the 1930s to address the needs of Jewish refugees, the International Rescue Committee (IRC) shifted after World War II to focus on providing post-emergency relief in conflict zones and areas affected by natural disasters. The IRC has been a leader in emergency response for more than 75 years. Its field teams have been key first responders to conflicts, such as the civil wars in Angola and Afghanistan, and natural disasters, like the 2004 Asian tsunami and the 2005 earthquake in northern Pakistan. Its field teams of experts, organized along key sectors (e.g., health, water and sanitation, protection of children, women and other vulnerable groups, shelter, and education), bring extensive experience and skill to working with people going through extreme trauma. IRC has special expertise in working with conflict-affected children and youth. The organization has long been at the forefront of developing culturally relevant approaches to supporting children's psychological, social, and physical well-being. Currently, IRC supports education programs for refugee and war-affected children, youth, and adults in 22 countries.

Photo by Melissa Winkler. Image provided by International Rescue Committee

MODEL IN PRACTICE 2 (CONTINUED):

Impact: Assessing the impact of efforts to meet the immediate needs of communities after a disaster is inherently tricky. The nature of an emergency is that it defies comparison and the chaos of these situations makes it difficult to collect data. Nonetheless, if you seek to address the physical safety, educational, and psychosocial needs of children immediately after a disaster, three indicators matter: 1) access to safe, child-friendly spaces, 2) children's participation in learning activities, and 3) availability of teachers who are trained to address the needs of students affected by conflict.

While it is far too early to report results in Haiti, results from other Healing Classrooms initiatives provide evidence of the model's promise. The following examples from Chechnya, Afghanistan, and Liberia illustrate the impact of the Healing Classrooms approach:

- Chechnya, Russia (2000, supporting people displaced by Russian / Chechnyan conflict): Study findings by an external researcher showed that simply providing a safe space for children in an emergency situation helped restore a sense of normalcy and jump-started the psychological healing process.[24]
- Afghanistan (2004, post-Taliban reconstruction and recovery): An independent study using interviews, surveys, and classroom observations found that after teacher training in the Healing Classrooms program, teachers improved and broadened their teaching techniques and were able to help students gain valuable life skills in other areas such as health.[25]
- Liberia (2006, post-conflict reconstruction): An independent study highlighted the ripple effect of the program's teacher training: 44% of the trained teachers in the program reported helping other teachers with lesson planning, a quarter of the trained teachers were offering mini-workshops and tutoring to their colleagues, and 20% reported helping peers with classroom management skills and strategies.[26]

IRC has also been engaged in two ongoing, longitudinal research projects in conjunction with the Harvard Program on Humanitarian Policy and Conflict Research. The first research project, launched in 1999, involves a study of the impact of IRC's non-formal education program on internally displaced Chechen children and adolescents residing in Ingushetia, Russia. The second project, launched simultaneously with a new IRC emergency education program in July 2001, examines the impact of emergency education on the psychosocial adjustment of Kunama children and youth living as refugees in Ethiopia. We anticipate these studies will provide important insights regarding the model's impact.

Photo by Peter Biro. Image provided by International Rescue Committee

MODEL IN PRACTICE 2 (CONTINUED):

TABLE 3: COST AND OUTCOMES OF HOME-BASED SCHOOLS IN AFGHANISTAN[29]

	IRC's home-based schools in Afghanistan	Government schools
Recurrent cost per student	$18	$31
Completion rate (through 5th grade)	68%	32%
Cost per graduate	$132	$495
Cost per learning outcome (passed end-of-year exam)	$134	Data not available

Costs: As of this writing (June 2010), cost estimates for implementation of the complete Healing Classrooms model in Haiti are not yet available. We do know that costs for such programs can vary widely from country to country and depend on many factors, including the availability of in-country staff, the availability of materials for classroom construction, and the capacity of local governments to provide materials and pay teachers.

IRC's current focus in Haiti is setting up child-friendly spaces that provide 15,000 children with a place to engage in recreational and non-formal education activities. Based on these current plans, IRC estimates costs for setting up such child-friendly spaces are approximately $75 per student/year. Transitioning them into more formal learning spaces over the next several months will require resources for initial setup as well as teacher training, materials for students and teachers, and activities to increase the capacity of the relevant education authorities.[27]

Operating costs differ in every country based on variables such as intensity of teacher training needed and amount of government support available. However, cost figures from Afghanistan provide a general benchmark of program costs for the approach. Home-based schools established during the Taliban years incorporated the Healing Classrooms approach and provided children with educational opportunities that were both safe and protective. For the program in Afghanistan, recurrent costs were $18 per student/year. This included teacher training that focused on the Healing Classrooms approach as well as materials and supervision. Additional costs included startup investments (totaling about $38,000) to address such areas as school rehabilitation, furnishing schools, and intensive training of teachers who have never taught before.[28] IRC's analysis found that home-based schools using the Healing Classrooms approach were quite cost-effective compared with government schools as seen in Table 3 above.[29]

Our team will continue to work with IRC and others to gain additional insight into the impact and cost-effectiveness of this model in Haiti. As new cost information is available, we will post updated profiles on our website: http://www.impact.upenn.edu.

Nonprofit contact: Sarah Smith, director of the Child and Youth Protection and Development (CYPD) Technical Unit at IRC: sarah.smith@theirc.org, or visit IRC's website: http://www.theirc.org.

Image provided by Save the Children

TIPS FOR ASSESSING INTERNATIONAL EDUCATIONAL PROJECTS:

In this section we focus on two models that provide education for children who otherwise would not be able to go to school. This guide provides two concrete examples of the models being put into practice by nonprofits, but there are many other effective organizations in Haiti and throughout the world that implement these evidence-informed models. For example, Pratham in India and Escuela Nueva in Colombia are nonprofits implementing community schools.

If you are interested in supporting community schools or an emergency education model, here is what to look for:

- *Expand access to education*. Especially in post-disaster situations, access, or the ability of children to go to school, is the critical indicator. In Haiti, a large percentage of school-age children lost access to education because their schools were destroyed and key personnel were lost in the earthquake. Even before the earthquake, many children did not attend school.
- *Address the factors that help children complete school*. These include factors such as whether the school is open and has teachers, whether the students attend regularly, and whether the school calendar enables students to attend. For example, in a rural farming community, the school calendar should synchronize with the harvest and planting seasons, which often involve whole families.
- *Ensure that learning is taking place*. Implementers should have a plan for measuring student learning and adjusting the strategies according to the results.
- *In emergency situations, education projects should meet the minimum standards laid out by the Inter-Agency Network for Education in Emergencies*. These standards ensure that projects address issues of access, completion, and learning outcomes but also take into account the specific challenges that arise in post-disaster or post-conflict environments.[30] For example, are the special needs of unaccompanied children being addressed?
- *In post-disaster and post-conflict situations, a high-impact educational aid project will address children's psychological needs as well as their physical and educational requirements*. Evidence has shown that education projects can significantly expedite the healing process when they incorporate curricula and teacher training that focus heavily on addressing the unique psychological needs of children affected by trauma.

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[23] The Inter-Agency Network for Education in Emergencies (INEE) is a global consortium of UN agencies, NGOs, donors, governments, and other representatives that work together to make sure that the right to education is provided to affected populations in emergency situations. The organization has published a set of standards that should be met by anyone working in emergency education in conflict or disaster zones. The INEE minimum standards handbooks can be found at http://www.ineesite.org/index.php/post/inee_minimum_standards_overview/#about

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Examples of these models outside Haiti

The models described in this guide have been successful in other parts of the world. For example:

HEALTH: Community-based primary healthcare systems have had significant positive impacts on health throughout the developing world. Successful initiatives include the Comprehensive Rural Health Project at Jamkhed in the Maharashtra state of India and BRAC in Bangladesh.

LIVELIHOODS: One of the models we highlight, the graduation model, targets the poorest of the poor, helping them create jobs for themselves and gradually integrate themselves into the economy. The Consultative Group to Assist the Poor (CGAP), in partnership with local organizations, is piloting this model in six other countries. The pilots are in: Ethiopia, in partnership with Relief Society of Tigray; Honduras, with ODEF/Plan Honduras; India, with Bandhan, Trickle Up, and SKS; Pakistan, with Pakistan Poverty Alleviation Fund Partners; Peru, with Asociación Arariwa/Plan Peru; and Yemen, with Social Fund for Development and Social Welfare Fund.

EDUCATION: Community schools and community-based education programs are being implemented all over the world. There is a growing community schools movement in the United States (Coalition for Community Schools) and many organizations use versions of the model elsewhere. Examples include Pratham in India, BRAC in Bangladesh, and Escuela Nueva in Colombia.

TIPS ON GIVING TO ORGANIZATIONS DESCRIBED IN OUR MODELS IN PRACTICE:

There are many nonprofits implementing the models we describe in Haiti. If you are considering giving to an organization we don't mention in the guide, we provide tips at the end of each section on the essential components to look for when assessing whether a program can deliver the type of results we present.

For donors who wish to give to specific nonprofits mentioned in our Models In Practice, please know the following:

- Every nonprofit described is a 501(c)3 registered in the United States. As a result, you can take the standard tax deduction for any donation you make to them.
- All organizations appreciate unrestricted funding as it gives them the flexibility to allocate funds to where money is most needed and to respond quickly to evolving situations. For this reason, we generally do not encourage restricted funding. However, if you wish to direct your funds specifically to efforts in Haiti or to a particular program model, simply indicate your intent at the time you make the donation.
- The organizations described in this guide are involved in complementary activities. In fact, many of them have formed partnerships with each other. Therefore, their efforts are not redundant, and you should feel free to give to as many of them as interest you.
- We have provided, for your convenience, contact information, website addresses, and a taxpayer ID number for each nonprofit profiled in our Models In Practice. (SEE TABLE ON NEXT PAGE.)

LIST OF NONPROFITS IN OUR MODELS IN PRACTICE

ORGANIZATION	CONTACT	PAGE NO.
Opportunity 1: HEALTH		
Hôpital Albert Schweitzer Haiti	www.hashaiti.org Natalie Hoffman, (412) 361-5200 Tax ID: 25-1017587	7 - 9
Zanmi Lasante/Partners In Health	www.pih.org www.standwithhaiti.org/haiti Christine Hamann, chamann@pih.org, (617) 998-8965 Tax ID: 04-3567502	9 - 11
Opportunity 2: LIVELIHOODS		
Fonkoze	www.fonkoze.org Leigh Carter, lcarter@fonkoze.org, (202) 628-9033 Tax ID: 52-2022113 Fonkoze's legal structure also makes it possible to invest equity and debt.	17 - 22
Catholic Relief Services	www.crs.org Jim Lund, jlund@crs.org, (410) 234-3135 Tax ID: 13-5563422	23 - 26
Opportunity 3: EDUCATION		
Save the Children	www.savethechildren.org Tim Rogers, trogers@savechildren.org, (203) 221-4242 Tax ID: 06-0726487	33 - 34
International Rescue Committee	www.theirc.org Sarah Smith, sarah.smith@theirc.org, (877) 733-8433 Tax ID: 13-5660870	36 - 38

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Please send comments about this guide to the Center for High Impact Philanthropy at impact@sp2.upenn.edu.

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