EMT Modules in Haiti:
Module based Capacitation of Critical Social Services

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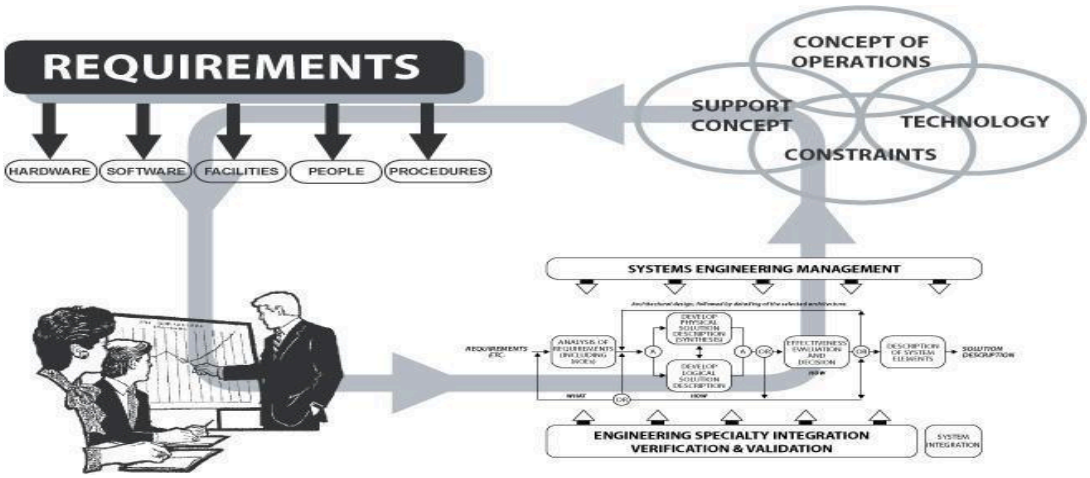

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Abstract

This Masters paper aims to validate a system of module based training deployed in the Republic of Haiti carried out between 2010-2015 based on an amalgamated core of Southern and Eastern development paradigms. *The Module itself is a Special Forces model of Emergency Medical Technician Basic (EMT-B).* But the underlying ideology of auto centric and emancipatory development provides a compelling example of what occurs when 'the beneficiary' is treated like a fully invested partner; sustainability & actual advancement of capacity.

Executive Summary

My research is a summary of how groups of multi-disciplinary & resource poor tactical development units trained 104 EMTs, 551 first responders and enabled them to build 4 distinct organizations that required no further capital inputs to self-sustain in the Republic of Haiti for below $241,000 USD with a simple idea and a modular expanding tool kit. This thesis will outline the practical application of an EMT Module in the Republic of Haiti and suggest eleven subsequent para-state module adaptations described as *Keystone Trades;* essential socio-economic building blocks to restore failed state function.

The delivery of health & social services is generally considered the responsibility of national governments and their appointed Health ministries. It is precisely these public services that were gutted under the structural adjustment polices advocated by the Washington Consensus and IMF economists in the 1980's (Stiglitz, 2002). Endemic global poverty brought about through structural violence has of 2015 resulted in 5.1 billion people living their lives below $5 a day (WB, 2015). The World Bank's $1.25-a-day poverty line is insultingly low. The United Nations Conference on Trade and Development (UNCTAD) states that anyone living on less than $5 a day is unable to achieve "a standard of living adequate for health and wellbeing": the inalienable right enshrined in the Universal Declaration of Human Rights. If these statistics are correct that would mean that over 71% of the human race; or 5/7 people are living in a state of emergency and deprivation (Kirk, 2015).

Concurrently 45 ongoing armed conflicts within 35 nations have weakened or disintegrated the capacity of many governments to maintain and deliver even basic social services (Uppsala, 2014). The gruesome civil wars have decimated populations and destroyed all but the most basic mechanisms of the state. Haiti has long been wracked by foreign invasion, internal political violence, and numerous coups. Adequate, Accessible, Available and Quality health & human services are rarely available outside of major cities in over 138 low and middle HDI countries due to reallocation, or expropriation via corrupt practice, of the limited available resources (Collier, 2007)(WHO, 2015).

The World Health Organization (WHO) calculates a global shortage of 4.3 million doctors. Using 2005 data in a regional census of African health workers it was determined that developing nations throughout Sub-Saharan Africa & the Developing world have highly limited

resources to train medical workers[1]. A variety of skilled professionals critical to forming just and equitable societies leave their countries to seek out higher pay in the urban centers of regional trade hubs and if they can; migrate to the global North West (Kinfu, 2009). Health Care has gone from being a human right and humanitarian imperative to a high lucrative global market, one that is experiencing a serious shock via the structural and regulatory barriers to train skilled medical workers. The catastrophic NGO influx into Haiti post 2010 earthquake are among the latest manifestations of that shock. Well-meaning foreigners providing non-regulated, uncoordinated and un-accountable development projects in lieu of private or public sector services controlled in country.

When a sustained process of underdevelopment expropriates a nations human resources, exploits the labor of its people and then exposes their fragile economies to the forces of un-mitigated free trade; the result is *maldevelopment*. One cannot make inherently dysfunctional structures succeed or failed states prosperous until critical investment are made in the human capacity to sustain and proliferate basic human services; particularly investments in health and education.

Pre-hospital care does not exist in any normative function outside of the OECD nations, where it does it is provided irregularly by Community Health Worker, low paid, quickly trained and existing with little to no uniformity of scope of practice.

The reason that the post-earthquake Cholera epidemic has ravaged Haiti is because few in the developed world took meaningful action until the situation was potentially threatening to global health. What is happening in Haiti must be examined in light of what is also happening in 59[2], underdeveloped & maldeveloped nations worldwide. It is not accurate to suggest that measurable improvements are being achieved (Farmer, 2003). The theory of change being accepted by the WHO and groups such as the *Clinton Health Access Initiative* (CHAI) is "human resources for health services", but what in what distribution; and by what pedagogy remains a serious question. If success is being measured in MDG health indicators[3]; then the Western Health Policy machine has convinced itself they are succeeding. But only those living in the West are giving themselves any pats on the back. Investing in stop gap maneuvers such as

[1] In the mere 12/54 African countries where information was available on the demographics of the health workforce as well as on graduations from national training institutions; disaggregating by physicians, nurses and midwives; in Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Kenya, Liberia, Madagascar, Rwanda, Sierra Leone, Uganda, the United Republic of Tanzania and Zambia.
[2] Utilizing aggregated data from HDI 2015 and Uppsala Conflict Index 2015 208 national units (adding the ISIS zone and Iraqi Kurdistan); 59 nations fall in the categorization of Low Human Development peripheral nations, including 35 countries recently affected by new or long running civil wars.
[3] HIV & Aids infections have been indeed been reduced. Measurable impacts, although not on target have been made reducing under 5-child mortality and maternal mortality.

affordable medications for infectious disease, community health worker proliferation, malaria nets, foreign volunteer medical brigades and expatriate trainings are token gestures offered by privileged Western academics, at best. They are not solutions to long lasting structural violence propagated by Western policies and local mismanagement. Those that advocate for them have clearly never lived on $ 5 or less a day in a violent, impoverished society.

No health system on earth has been designed to allow the base level practitioner, in this case the Community Health Worker, to advance via testing and modular training to the level of a specialized physician. It is that precise service system we seek to proliferate in both Haiti and West Africa and in the process demonstrate the speed and proficiency we can build back social services in developing nations.

Acknowledgements

This work was a very long time in the making and took a great deal of generosity, risk and time from all those that were involved. When this began in the fall of 2010 no one supported this effort, in fact all the experts told us the Haitians would steal our equipment and malign our civilian volunteers. We were told that we were unequipped for an operation of this scale and what could a group of ambulance workers know about sustainable development. Five years later the Clintons have built a $470 million sweat shop called Sai-Ah; the proliferation of un-registered NGOs continues unabated; people continue to profit off Haiti's poverty and there is still no emergency medical service in any normative form. There is however confirmation that anti-Haitian pogroms are happening in DR, the rock star neo-Duvalierist President has not called elections in over a year and perhaps as much as 20 billion in gold has been found in the north of the country being prospected by American companies.

However, thanks to rank and file EMS members of service connected with the Banshee Association in New York and Empact Northwest in Seattle; 104 capable, utilized and employed Emergency Medical Technicians have been trained in four classes in Haiti. These men and woman are employed at hospitals, on ambulances; they have formed Haitian organizations that function without foreign direction. They save lives and train others.

Our work would be impossible without the bravery over sixty-four EMS personnel from around the USA who raised money and equipment; who flew to Haiti wave after tumultuous wave to teach. Special thanks to Gerard and Geraldine Prévot of the GAI; who held the Haitian formations together throughout un-ending adversity. Without them and Haitian nationals like Obenson Etienne, Lucien Bonhomme and Claudel Gedeon Haitian EMS would be a foreign invention. These men and women built GAI, RETUM, MASHA and EMPACT Haiti the

autonomous EMS groups that emerged from each class. On the diaspora side; without the support of Sonide Simon, Sam Darguin, Victor Cange, Watson Entwissle and Ken Francois we'd have been unable to connect out theories and modules to the support base of the diaspora.

Special thanks to Michael Mastroianni, Armandeus Davidson and Eric Adman the elder statesmen paramedics of the effort that tempered Banshee radicalism and provided decades of EMS supervision. Special thanks to Elena Antolievna Komarova who utilized her training in Educational Development to upgrade the fourth version of the EMT Module and make it so replicable and lean; she alongside Peter Reed served three months in Haiti alongside this author in the summer of 2014 to prove the module could run at a fraction of the previous staffing costs.

At Heller, with the exception of Jefferson McIntyre I got so used to dirty looks due to my comments on development that I will never in my life call myself a development practitioner. With the exception of Profs Sampath, Howard and Abt more blank looks from the faculty made it clear that 100K in debt, having carried out five years of medical capacity building and arguing passionately for the poor and oppressed is not welcome at this university. I feel that I have no support for this module, no prospects for deployment and no future for this work other than that what I will create. I have learned that a happy class of people have taken poverty alleviation as means to live well off the backs off the poor in a field that is unaccountable and in denial about its own impacts. One day they will throw development practitioners in prison as profiteers and I expect to see many of my classmates at that trial.

Without my mother, father, Elena and Alan Medvinsky I am sure I could not have sustained the graduate school experience. I only hope with all this new training and wider perspective I can put by research to more good work.

Acronyms and Abbreviations

BRAC	Bangladeshi Rural Advancement Committee
BRICS	Brazil, Russia, India, China, South Africa's New Development Bank
CBO	Community Based Organization
CHW	Community Health Workers
CSI	Community Supported Infrastructure
CPR	Civil Political Rights
DAC	Development Assistance Committee
EMT-B	Emergency Medical Technician Basic
ESCR	Economic Social Cultural Rights
FTZ	Free Trade Zone
GAI	Gwoup Ayisyen pou Ijans/ Haitian Emergency Group
GCC	General Coordinating Committee
GDP	Gross Domestic Product
GNI	Gross National Income
GINI	GINI index
HDO	Hybrid Development Organizations
HHTARG	Haitian Hometown Associations Resource Group
IMF	International Monetary Fund
IK	Indigenous Knowledge
IN	Indigenous Need
ISM	International Solidarity Movement
MASHA	Movement of the Rescuers in Haiti
MCA	Mass Capacity Approach
MCD	Mass Capacity Development
MCM	Mass Capacity Modules
MbT	Module based training
MDG	Millennium Development Goals
MINUSTAH	United Nations Stabilization Mission in Haiti
MSPP	Haitian Ministry of Health
NGO	Non-Governmental Organization
OECD	Organization for Economic Co-operation and Development
PST	Parallel State Theory
PALMA	Palma Index
RMA	Rezo Medikal Ayisyen/ Haitian Medical Network
RETUM	Network of Emergency Technicians
SDG	Sustainable Development Goals

SMO	Social Movement Organization
TED	Technology Entertainment Design
UNDP	United Nations Development Program
USAID	United States Agency for International Development
WB	World Bank

Introduction

2.4 million people living in Port-au-Prince, Haiti lack access to basic pre-hospital emergency care and die of preventable illness and injuries. In 2005, the World Health Organization recommended pre-hospital care as an integral building block of emerging health systems. However, Emergency Medical Services (EMS) as understood in developed countries are virtually non-existent throughout the developing world.

The theory and practice of Module based training is to permanently provide high quality emergency medical service training consistent with Anglo-American standards to resource poor populations within developing nations. We use an innovative systems based approach to train healthcare workers in remote, austere and resource poor environments. Our solution was to expand the scope of practice of the Community Health Worker through a series of paraprofessional training modules. Beginning with a CHW upgrade to Emergency Medical Technician (EMT) our module system focuses on three core aspects:

- **Generate independently employable human resources for health services.**
- **Enhance the capability of existing community based healthcare organizations.**
- **Empower local capacity for continuing medical education and local training.**

We have developed and rigorously field-tested (over five years and four clinical trials) a for-profit, hybrid solution to pre-hospital care delivery. Our training methodology can quickly, efficiently and cost-effectively improve the medical services of resource poor communities within developing nations. Our pilot program is successfully running in Port-au-Prince and Croix-des-Bouquet in Haiti. We have so far trained 104 EMT providers and 551 community first

responders the majority of which are employed in the health sector. We are now seeking funding to establish permanent operations and scale up.

This thesis paper will build upon these Eastern and Southern case studies and demonstrated praxis to outline a bold new methodology of development called **Module based training (MbT).** It will then illustrate the applicability of this hybrid modal for proliferation via all four sectors of the enterprise. **The thesis paper will be arranged into several categories of analysis; 1) Background & Development Context, 2) a Case Study, 3) Methods, 4) Literature Review 5) Discussion 6) Recommendations, followed by and Annex which will include 7) a Cost Effective Analysis, 8) Assumptions & a 9) Listing key stone trades.**

We will recommend financial and operational facilitation of the 12 Key Stone Modules in 130 peripheral, least developed nations and conclude with immediate next steps for international implementation. Specifically and immediately, in Haiti, DR, Jamaica, Sierra Leone and Greater Kurdistan. The logic of these locales will be explained in some depth. The goal of each emergency group is to establish a useful beach head to advance further trainings and correlated social enterprises.

Background & the Development Context

What if a crime of enormous magnitude was being carried out in the most sanctimonious and white washed paradigm imaginable? Perhaps in the name of social justice, gender equity, human rights and democracy. A great and unnatural pillage of humanity and planetary resources being carried out as a civilizing, modernizing mission. Preceding at such an alarming rate that 5 in 7 humans were as of 2015ce reduced to varying degrees of miserable serfdom and the climate itself was being altered, rendering the ecosystem hostile to life. What if an international web of small clustered elites were via their accumulation of wealth concentrated in several developed nations. And these elites we able to not only shape the dominant socio-political discourse; they were able to carry out their expropriation by calling it "development."

The Development Enterprise as we understand it began after the Second World War with the 1948 implementation of the Marshal Plan[4]. The intention of this far-reaching US Aid

[4] The **Marshall Plan** (the **European Recovery Program**, **ERP**) was the 1948 American aid program directed toward Western Europe and Asia contributing $13 billion in economic support to rebuild, promote free trade and improve business infrastructure after World War 2 to deter the spread of Communism.

investment was to keep war-ravaged Western Europe from being absorbed into the Soviet sphere. Development subsequently evolved into a far more expansive international architecture. Its newly stated intention within the Cold War context was to modernize & industrialize the former colonial, third world and later the Post-Soviet nations. Packages of civilian and military aid were coupled with technical assistance. Non-governmental organizations proliferated generally around poverty alleviation and cause specific programs. The United Nations ratified a wide range of human rights instruments as rapidly escalating armed conflicts accelerated in almost every nation in the developing world. By 2014, there have been 15 confirmed acts of Genocide by International Law since 1945, 37 total if you include acts of democide (Rummel, 1998). Environmental degradation has resulted in expanding disastrous climate change (Nordhaus, 2013). There are over three billion human beings living at or below $2.50 a family a day that are worth as much in their collective assets as the top 83 richest people on earth (Oxfam, 2014). It is believed that over 29.8 million people still live in chattel slavery (Global Slavery Index, 2013). That number might expand tenfold were we to incorporate low paid, race to the bottom type assembly plants and bonded labor. While the United Nation's Millennium Development Goals have supposedly 'halved global extreme poverty', 'doubled human access to clean water' and 'halted new infection with HIV-AIDS' divested of all the many political, economic and religious superstructures the results of the development enterprise are highly underwhelming. Largely unmeasured, unaccountable and top down in implementation; if not an outright architecture to maintain former colonial relationships between states referred to as dependencies (Rist, 2002); development lacks to a growing body of humanity whatever moral imperative it once enjoyed.

Development today is a highly subjective and amorphous field that lacks measurement or even an agreed to verifiable definition (Rist, 2007). Within the ranks of this vast and ambitious undertaking are bright eyed idealists; ego maniacs; missionaries, spies; colonialists, national patriots and aspiring revolutionaries. Economic opportunists are everywhere. As well as wolves in sheep's clothing who in pursuit of bare national & self-interest leave not a scrap for the future. This global enterprise of unprecedented scale relies upon various competing theories of change and remedy, constantly in antagonism. That the needs of the present generation do not outstrip the prosperity or availability of future generation's needs; juxtaposed to a Kuznets curve positing that rising inequality precedes equity. Concentration on Sen's maximization of agency & capability; or breaking physical and mental dependency via Paulo Freire's pedagogy of the oppressed. Does one glorify the United Nations and multilateral big-push theory and Sachs' Millennium Villages or endorse Easterly's social entrepreneurial searchers and the Monterrey Consensus. Does the future look to John Smith via 'Free Market Fundamentalism' or to the ghost

of Karl Marx? Human Rights or human needs; the 'ease of doing business' or the 'dictatorship of the proletariat'. Capacity or capability? Do developing nations borrow from the World Bank or BRICS; is the worldview of the practitioners shaped by World Economic Forum or World Social Forum. Where do we ultimately place priority and resource mobilization; within the social, the economic or environmental sphere? Does work actually set people free? No one knows, or can know, the answer to any of those questions. Largely due to a total lack of objective and transparent data[5]. We must refuse to accept the validity of government statistics being produced by governments that cannot meet the most basic social services such as feeding, housing and providing healthcare and education for their people. We must also reject systems of Monitoring & Evaluating any data that are carried out by the same institutions that the data reflects performance upon. The World Bank in 2001 conducted a massive participatory study of poverty where tens of thousands of people living below $1.25 a day were asked what could be done[6]. When the UNDP in 2014 asked similar questions to over 1 million people about the 'world they wanted' it was still obvious; the interests of the powerful few, the narrow interests of the oligarchic elites persist in smothering the voices of the poor, silencing all calls for change and imposing upon us all the vision of acceptable development, modernization and social progress (Piketty, 2014).

Underlying all this chaos and urgency is the objective reality that over 4 billion human beings are living in varying degrees of wretched deprivation, dying miserably before their time (World Bank Data/UNDP 2015). There is a very harmful dual untruth being perpetuated by majoritarian development actors in the United States and Europe. It is based on a *dual illusion* that has been furthered by big media apparatuses and financed by the corporate, business & banking sectors which also fund the various political parties in high office with direct bribes, indirect bribes and campaign financing.

The first part of this great un-truth is that **human progress is a proven fact upon the ground**; that the world is gradually getting freer, safer and more equitable; exemplified by indicators such as trade statistics, GDP and the Millennium Development Goals[7]. This is the world view offered by TED Talks pundits, the neo-liberal theories of economist Jeffrey Sachs

[5] One trusts official government statistics or one does not.

[6] Leading up to their World Development Report 2000/2001, the World Bank and Oxford University commissioned three entire volumes resulting from a global consultation with 'the poor'. In Volume 1, 'Can Anyone Hear Us?' they interview 40,000 poor people in 50 countries, In Volume 2, 'Crying Out for Change' compiled 1999 its inquiry in 23 countries). In Volume 3, 'From Many Lands' poverty patterns and country case studies are conducted. 'Voices of the Poor' calls for an expanded definition of poverty and an examination of power dynamics that enforce it

[7] The 8 MDGs were a United Nations global anti-poverty goals largely proven to be unrealistic and partial in their implementation soon to be replaced by 17 proposes Sustainable Development Goals in September 2015.

and revisionist academics such exemplified Steven Pinker. That poverty is ending and violence is ever decreasing.

The second part of the untruth is that **capitalism and globalization are the drivers of this equitable progress and that market forces are ultimately good for the poor.** The so-called 'hard data' that we have on hand does not well substantiate either highly muddy illusion. Both of which are paradigm hallmarks of a North Western development consensus which has for too long been operating unaccountable to all those it claims to serve, while attempting to maintain a monopoly on development and its discourse. We cannot reasonably prove in a scientific and objective way that Walt Rostow's modernization theory is actually even occurring. We cannot prove that global violence, war and conflict is markedly decreased from unestablished, and largely un-kept statistical base lines from all the ages before 1848 (most of world history); and most importantly; we are being intellectually coerced (and coddled) by Western academics, politicians and economists to embrace a growth-obsessed, econometric free market fundamentalism simply on the basis of the competing ideologies battle field defeat[8]. The famines, gulags, atrocities and repressions used to chronicle the civil warfare transitions from backwards feudal and peasant societies to 20th century socialist incarnations are direct exacerbations of top down socio-economic transformations in a state of perpetual cold and hot proxy war with the Western capitalist system. Russia and China have without a doubt gone in the course of less than one hundred years from being defeated, long victimized semi-feudal peripheral powers to super power hegemons and serious core contenders (Wallerstein, 2004)(Amin, 2006).

There can be no clear and absolute measurement of the data being generated to verify progress in the Human condition despite what various experts attempt to claim. The numbers on hand at the United Nations and World Bank are supplied by statistical ministries in a variety of highly non-transparent [if not overtly corrupt and incompetent] national governments aggregated to produce results that do not tell full or even partial truths. Despite what is being claimed at global conferences; we do not actually have much valid comparative data on the human condition before 1848 (Foucault, 1988). At the 2013 Interaction Forum, the broadest confederation of American development NGOs and Humanitarian actors, the UN High Commissioner for Refugees António Guterres admitted, "We are not entirely prepared". More conflicts, deeply entrenched poverty, coupled with the targeting of aid workers will occur alongside decreases in funds and the impacts of global climate change. Yet, across the western development enterprise, almost all of the Western and white-washed academia and technocracy seem to agree that the very worst of human civilization is behind us (Pinker, 2013). Climate

[8] Revolutionary Socialism and Communism were defeated largely on the basis of attrition and proxy warfare, not due to lack of social provision.

change and gender equity are to subsume talk of structural human rights achievement and class warfare as the acceptable development discourse.

There still is massive disagreement regarding the hierarchy of immediate needs for those 5 billion human souls that live on less than USD 10 a day; 4 billion at below $4 per family per day. 3 billion of which live on less than USD 2.50 a day; and 1.2 billion on less than USD 1.25 the number of which living in Sub-Saharan Africa which may in fact have in the last decade doubled (World Bank, 2015). The economist Thomas Piketty argues in his 2014 book *Capital in the 21st Century* that not only has there never been such wealth & income inequality ever in recorded history; but that at present rates oligarchic wealth accumulations are increasing and ultimately highly destabilizing to both markets and democracy.

The question remains one of enlisting actual participation and empowerment, not governance. Will listening to the 'voices of the poor' be a meaningless slogan or a set of specific instructions to those invested in actually achieving equality? Will development amount to economic enrichment of existing elites, corrupt governments and be the political aid carrot to the military stick; or will development mean emancipation from poverty and a tool kit to achieve freedom from long running structural violence (Goulet, 1971).

Development economist Amyarta Sen believes that development is a means to achieve freedom and freedom is achieved by enabling human capability. Jeffery Sachs believes poverty can be eliminated though coordinated action via a big push style global Marshal Plan. Banerjee & Duflo argue that not until randomized control trials drive interventions are we truly transparent and accountable. Many denounce development itself as a neo-colonialist scheme (Amir, 1973) and regardless of your political tendency one must admit the same actors of the North West dominate. OECD countries are theoretically bound to be giving 0.7% of GDP in direct foreign aid, to be matched by 0.3% via private sector charitable giving. However all rich, high HDI nations seem to prefer the 2002 Monterrey Consensus; to invest in trade related infrastructure. A regular buzzword in the enterprise is 'Capacity building', but this is often limited to technocracy and management training going directly to the government/public sector. Throughout the development and humanitarian sector coordination is irregular, local participation is largely dictated top down, and dependency is fostered beholden to national political directives, or just simple failure to meaningfully empower the so-called beneficiaries.

Development cannot easily be grouped by proponent origin geography, but a grouping of tendencies in methodology can be identified from their sources. It is important to remember that Development is not purely about donor and beneficiary nations; there is a clear linkage between

internal national developments of a governments own population and external projection of its development paradigm. Development fosters dependency inherently; citizens dependent on government services and developing nations dependent on developed ones; their economies wide open their resources and cheap labor reserves ripe for picking.

There has emerged in the developing world a variety of effective means to break that dependency and unleash the human capability Amyarta Sen was referring to. **Southern Development (**Bangladesh, India, Cuba and Tanzania) is often categorized by utilization of micro-finance as credit base for social programs, encouraging self-reliance, directing investment internally and promoting massive capacity investment via vocational training in vital services. In the experience of **Eastern Development** (emanating from Russia, China, Israel and Iran); development focuses on construction of fixed infrastructure, long term investment in education & health, large scale/ long term cultivation of local leadership capacity and highly replicable localized mass training.

As opposed to **Northern Development** (Advanced Welfare States) largely concerned and successful with their own citizens development; and **Western Development** (emanating from the European Union and the United States via the OECD) that focuses predominantly on excess asset dumping, promoting market deregulation and free trade policy, augmenting perceived comparative advantage, supporting widespread privatization; and in the era of Gates philanthropy pushing disease surveillance, availability of inexpensive pharmaceuticals, women's literacy [and inclusion in the work force] as well as advancing shallow policy changes in socio-political culture and asserting entrepreneurship when and where ever it can be advanced.

Within local Non-Governmental Organizations (NGOs), Social Movement Organizations (SMOs), trade unions, religious intuitions and Community Based Organizations (CBOs) of the so-called Global South[9], but in actuality economic dependent periphery; maximized human resources are often the primary asset they have to work with. Cut off from mega donors, domestically or abroad and often from services typically provided by government; innovation has been the key to community survival, which has superseded international external development strategies rarely aligned with political realities. A result of that innovation is the understanding that development is best implemented through indigenous knowledge, through

[9] The ridiculousness of labeling and linguistics has emerged a critique of development itself. The Cold War divisions of first, second and third world no longer have resonance. Developed v. developing posits that one countries Modernization (Walt Rostow) was not predicated on the under-development of another country. Therefore Global South/ Global North is yet another simplistic layer of false conscious thinking. Firstly, because economic relationships define international relations and this paradigm fails to even address that. Secondly, because no country is wholly developed, in even the most OECD developed nation there remain pockets of absolute under development. Therefore North and South are misleading neo-liberal monikers. They have no resonance in economics, sociology, history or political science.

local control of the means of development; and through investments in skills and training called **Mass Capacity Development (MCD)[10].**

My research work is being driven by development programs initiated in the Global South/Periphery[11], but the theoretical construct is Eastern in origin (Rist, 2011). The world is divided into 216 economic, quasi-national zones. While it would be largely accurate to state that the core of the world system lies in the global North and West; it would be wildly inaccurate to think this is a static reality. There are multipolar challenges coming from the People's Republic of China, the Russian Federation and India. There are a myriad of shifting paradigms in development methodology. Particularly those activities occurring in Cuba, Bangladesh, but also in New York, India, Israel and Iran. While this may seem a highly irregular data set the following findings are emerging that will revolutionize the system of Development Capacity Building. To transform the enterprise completely from one, which focuses on barely meeting human needs to one that generates human rights achievement via mass capacity. From Cuba we have seen some of the largest medical deployments in human history; an estimated 50,000 medical workers and comparable number of teachers and construction workers (Feinsilver, 1993). A full 6% of Cuba's GDP is generated providing healthcare, education and construction of infrastructure to the developing world. Its population is 99% literate and has better health indicators than the United States. Bangladesh has facilitated the birth of the world's largest NGO BRAC. Over 102,281 people (BRAC, 2012) employed in a massive hybrid system that cover 70-80% of its own operational needs though social industries. That runs major businesses, micro creditors, schools, health services and paraprofessional training. The Acumen Fund in New York has set up over 82 major social enterprises in the global south through their implementation of patient capital. Israel has developed sophisticated training systems in health and agriculture to generate functional cohorts. Its state formation itself was a demonstration of parallel state development. Iran has made incredible progress through an innovative system of community health workers called the *Behvarzan*; it has also demonstrated via *Hezbollah* in Lebanon its ability to rapidly introduce Para State functionality and security in a war zone. Beginning in 2008 India via the Indian Skills Development Corporation has set out to provide vocational training to millions of it is citizens via a vast public-private partnership.

[10] MCD posits as a development theory that promotes massive investments in skill and vocational training in all sectors as viable means to advance the conditions of the poor.

[11] The "Global South" is an erroneous term of Western Development misleadingly indicating that development can be spatially identified in a fixed geographic zone. Core, Semi-Periphery and Periphery as delineated in Wallerstien's World System Analysis better expresses the dynamic nature of these economic zones. Dynamic in relation to both geography and development.

The true "economic miracles" of the last twenty years were not those countries which followed the advice of Washington Consensus; they were not the captive Asian Tigers[12]; they were China, India, Bangladesh, Vietnam and Ethiopia who generally ignored the basic elements of the Washington Consensus completely (Rodrik, 2002).

There should be no mistake that development is highly complex, perhaps the most ambitious undertaking of human civilization; an organized and sustained campaign to alleviate massive human suffering and injustice. However, whether we in the North West wish to admit it or not; most of the leading causes of underdevelopment were & are the direct result of social, military and economic polies initiated by developed nation governments (Blum, 2003). We must operate in the realm of realpolitik, but we must also draw definitive lines between what is in the interests of the long suffering masses of humanity verses what is done in our own so-called national interests, to secure the lifestyles and wants of the developed world at the expense of the majority of the species. Mass Capacity Development is not adversarial. It does not pit nation against nation or posit a new utopian political order. Instead, modular vocational development is the great leveler that allows all who are willing to engage in productive social enterprises to have doors open to their advancement. It places development back in the hands of the community while engaging the recommendation that development and aid are best directed not at state systems but towards striving masses yearning to acquire a means to fish. Dependency is not broken with a 'leaky begging bowl' but with the skills and training to invest in ones future (Escobar, 1995).

The Development Enterprise has regularly circumvented the local populations of the developing world by focusing aid into the opportunistic private sector, often corrupt public sector or via foreign dominated and culturally hostile NGOs. Development too often ignores the capacity of local people and focuses on the capacity of increasingly failing states (Collier, 2007). Throughout the history of development since 1948 the politics, economic needs and priorities of the North West have not only shaped the way we are taught to view human progress, but also tethered more than half the human race to the most wretched and deplorable living conditions imaginable.

The concept of multi-disciplinary vocational/ technical paraprofessional training coupled with the formation of civil service enterprises (CSE) is seemingly anathema to North-Western development, but remains at the fore front of South-Eastern/ South-South development

[12] The Asian Tigers; Singapore, Hong Kong, Taiwan and South Korea share several factors. All are relatively small in population, mono-ethnic, dependent completely on the U.S. for their defense, isolated politically and military by the PRC and dominated by either local military rule or oligarchy until very recently, if not in reality to this very day.

exemplified by Russia, Cuba, Israel, Iran, Bangladesh and the People's Republic of China. Responsible elements within the global development enterprise must become not only "accountable to those they serve" but work actively to break all forms of foreign dependency; especially in this a new era of unstable Multipolarity.

The future of development must assume a marked departure from the imperatives of the former colonial powers as well as those emerging hegemons that are effecting core shift from 'West to Rest' via the BRICS. The gross human rights violations and structural injustices that have been perpetrated via the world system have resulted in 3.5 billion humans living below $3 per day, 45 active low, medium and high intensity armed conflicts (Kaldor, 1999) (Uppsala, 2015), vast deterioration of our climate via CO2 emission and unprecedented wealth concentrating the worth of half the human race in the hands of just 83 individuals (Oxfam, 2015). The perversity of this reality bears it being repeated.

This thesis via its interpretation of several eastern theoretical frameworks; organizational case studies and direct RCT[13] field implementation of the suggested approach recommends that the blue print to emancipatory development via human rights and justice lies no longer in hands of the North-Western powers that have for 500 years demonstrated both their tendencies toward proliferation of both conflict and exploitation (Wallerstein, 1974). Nor does it fall evenly into the three sectors (private, public and NGO) that so far have failed to meaningfully deliver development to more than half of the species.

The micro-problem is the wholesale refusal to admit 'development as a political act', the inverse of interstate warfare. A system of theory, technology and praxis carried out upon a targeted population group. The macro-problem is that those that designed the architecture of the development enterprise had no intention of relinquishing their power differentials or their own hyper-development[14].

This thesis will build upon these Eastern and Southern case studies and demonstrated praxis to outline a bold new methodology of development **called Mass Capacity Approach (MCA).** I will then illustrate the applicability of this modal for proliferation in all four sectors of the enterprise. It will draw on historic as well as contemporary examples to demonstrate the validity of development efforts to achieve equitable societies and human rights security through

[13] RCT, randomized control trials was a system developed by Duflo & Banerjee via the J-PAL at MIT to compare the results of a given development intervention against indicators from randomized control segments of the population chosen to not receive the intervention at all. The principle of RCT was that every single development intervention must be able to prove in implementation via hard, measurable data that it is actually improving the lives of the beneficiary population.

[14] Overabundance & over consumptive behavior to the point of causing harm and deprivation to person outside the benefit structure, as well as the planet.

Parallel State Theory (PST); the demonstrated development paradigm that allows communities to fully control the terms, planning and implementation of their own development.

The solution to this series of overlapping, multi-dimensional problems which have yielded the contemporary tapestry of mass human rights violation is a massive investment in fourth sector[15] human capacity via the trades and professions most needed to alleviate this highly systemic injustice. To wean humans off unnecessary dependency; political subservience to local elites often directly linked to the economic domination by foreigners.

Poverty is not a naturally occurring phenomena such as the weather. It is the social result of political decisions on how to allocate national resources and organize ones economy in relation to a global trade and production system.

According to Yale Sociologist Immanuel Wallerstein, there has since 1500 CE existed a World Economic System dominated by the political directives of a Core power hegemon or Core block of powerful interdependent states. While historically speaking large empires had existed and marshalled wide swaths of regional control or trade; not until the emergence of capitalism, industrialization and globalization could a singular state or alliance impose control upon the global population. The first power to do so was the Netherlands, followed by England. Slavery and colonialism were the outward manifestation of this new order. The World Wars[16] were a contest for this core dominance between Germany, Japan and the United States. At the end of the World Wars the U.S. effectively launched the Development Enterprise with the Marshall Plan in Europe to shore up its nation's against the advent of revolutionary socialism. By 1950, a bipolar world system of competing economic hegemonies (super powers) pitted the U.S. against the U.S.S.R. which was defeated after the ensuing protracted Cold War between 1989-1991. In 1978 the People's Republic of China embraced state capitalism and began ramping up as the world's factory a production machine of previously unknown capacity that would subsequently lift 688 million people out of extreme poverty (UNDP, 2015). The U.S. and its NATO allies enjoyed an unprecedented period of hyper-power dominance until 2001. By the time of September 11th attacks and certainly by the 2008 global recession it was clear that core shift was occurring

[15] The fourth sector is a broad amalgam of civil society actors such as community groups, social movements, farming collectives, clubs & associations, trade unions, religious institutions and grassroots actors funded directly by the local community they operate in.

[16] Wallerstein posits that both World War 1 & 2 being initiated by a similar belligerent Germany for world core dominance was historically a singular event not two dissociated periods.

toward China, especially in light of the BRICS alliance[17], a direct development challenge to the Bretton Woods Institutions and Euro-American hegemony (Amin, 2006).

This is not just another academic indictment of the development enterprise. It is first and fore most an analysis of the most noble and effective elements that have persisted throughout the quagmire because of the simplicity of their implementation.

Haitian Case Study

Haiti carries a unique and symbolic place in the hearts and minds of the developing world as it was here in 1791 that a slave uprising first began to roll back the grisly forces of slavery and colonization. For that Haiti has paid a price of quarantines, coups, foreign occupations, brutal dictatorships and an indemnity payment to France valued at $27 billion dollars paid off until 1947. To ask why Haiti 'is so poor' or deny her modern uses is disingenuous (Farmer, 2005). When one considers the sheer scale of human poverty; development practitioners and economists are at a repeated loss to identify a just solution, much less a singular once.

Often people speak of capacity as removed from 'teaching people to fish', as though that were somehow counter intuitive. We are therefore by redacting complex development and political science to that ancient maxim, but going a step much further. We seek to teach people how to save lives in a pre-hospital setting, heal, and teach their nations empowering self-reliance. To accomplish that we have enlisted in this case the Haitian diaspora in every step of the

[17] BRICS is an economic development alliance between Brazil, Russian Federation, India, China and South Africa founded in 2009. Collectively they represent an estimated 3 billion people (40% of human species), with collective GDP of 16.039 trillion USD (20% of Gross World Product).

planning and implementation. Our impact will be to turn the symbolic victim into the practical rescuer. We have generated livelihoods with dignity and fostered development with substance.

This case recounts how in January of 2010 a group of emergency medical workers, fire fighters, development practitioners and members of the Haitian diaspora dispatched a series of volunteer brigades to Haiti and over the next five years deployed the methodology of module based development to achieve a tangible human rights based health intervention.

A series of human and environmental catastrophes have befallen the Republic of Haiti since the moment of her independence. It has repeatedly been stated that Haiti bears a certain 'uniqueness'. I assert that this 'uniqueness' is artificially enforced to the detriment of all her citizens and must be corrected by political action. She is the most disaster casualty prone nation in the Americas (UNOHA, 2014). She is the absolute poorest nation in the Western Hemisphere and second only to India the highest perceived ratio of NGOs/to population on earth (Clinton Global, 2012). Perhaps more striking is that her income inequality is seventh most unequal on earth (2012 GINI is 0.61). She is also the only nation on earth with a peacekeeping operation presiding over our military jurisdiction without a ceasefire in place between warring factions.

There are now 10.32 million citizens now living in the Republic and they are living with daily existential threats to their general welfare and survival. Currently their HDI is 168/187 (0.417). Haiti has an adult life expectancy of 63.1. A full 50.16 % of their population is living in multidimensional poverty (UNDP 2014). A 2012 World Bank survey places 6 million Haitians (59%) living below $2 (90 HTG) a day while 2.5 million (24%) are living below $1(45 HTG). Therefore 83% are below their own domestic poverty line. Adult literacy is at 48.7% (UNDP, 2014). Only 5% of the population can functionally comprehend French; our language of education and administration (MIT, 2014). Only 10% of the population are employed in a taxable sector (World Bank, 2014). Their state does not currently have the capacity to exert full sovereignty (Farmer & Schwartz, 2014). This is derived from a combination of stressors; a) having no substantial tax revenue base; b) donor circumvention of state structure in delivery of aid via NGOS; c) the sensitive nature of our domestic politics; c) ongoing MINUSTAH presence; e) the lack of an armed forces and underdeveloped police force; d) and NGO proliferation (Schwartz, 2014)(CFPS, 2014). If we examine USAID development policies ranging from HAVA to subsequent newer incarnations, we observe not only several generations of clusters that paid only lip service to the authority of the state, but also demonstrated non-coordination facilitated by USAID subcontracting to both NGOs & Beltway contractors (Schuller, 2012).

A range of capacity building priorities will require both management training and eventually takeover of wholly inadequate NGO facilitated services (NORD, 2014). MINUSTAH

policies which once urged 'clusters' now suggest a firmer hand in regulation of NGO actors in Haitian soil. On either end of this extreme are polices of India v. NGO policies of Sudan (Oxfam, 2012). UN OCHA 2014 policy recommendations involve development of command and control over NGOS, public-private partnerships, extension of microfinance sector; new tax identity cards, direct taxation of remittances and transfers, as well as extension of sales taxes on items in the large informal economy (World Bank, 2014). According to the GAO Congressional policy studies in the US; of $631 million allocated to our post-2010 reconstruction: 0.7% went to our government, businesses or organizations; 43% was routed to NGOs and a full 56% was reinvested via contractors. 55% of obligated pledge has evens been delivered (GAO, 2013)

The NGO sector remains totally unaccountable, over 46,000 predominantly Euro-American aid workers constitute a demographic Haitians refer to as *Klas ONG*; the NGO Class. As of March 31, 2013, the U.S. Agency for International Development (USAID) has obligated $293 million (45 percent) and disbursed $204 million (31 percent) of $651 million in funding for Haiti from the Supplemental Appropriations Act, 2010: less than 1% has gone to their government (USIP, 2010). While officially, there are 560 registered NGOs, there may be at any given time upwards of 5,000-10,800 formations (missionary, humanitarian, and domestic) dispensing services illegally in their territory. Perhaps not with malice, but with total disregard they have been reduced to predatory dependency, regulating them will be highly complicated (Chafetz, 2006)(Schuller, 2012)(USIP, 2010). Reduction of duplication and overlap most coincide with thorough monitoring and evaluation.

'Open for Business' legislation has allowed a degree of exploitation of the Haitian labor force and further destruction of their environment (Johnston, 2013). Investment policy should shift away from *maquiladora* garment assemblage (Titus, 2012). It should absolutely enforce state ownership of resources especially in light of the recent discovery of an estimated 20 billion in gold (HGW, 2014). Investments have been made to replicate the Dominican Ministry of Tourism's Dual Track; segregated all-inclusive hotels on the coast and islands used to pay to more culturally sensitive development open to all within the interior. Investments in garment assemblage at Sai Ah Industrial & export-processing zones is not a proven model for development (NY Times, 2014). Through U.S. legislation such as HOPE I & II as well as the Help Economic Lift Program (HELP) Acts Haiti retains duty free access to the US. (Chandler/ Clinton Global Initiative). Capital inflows from the diaspora are estimated to be $1.5-1.9 billion a year (23-30%) of their 2010 GDP Most of the existing policies in place to empower the diaspora to reinvest financial and human capital are only proving partially effective (Titus, 2012). Allowing dual citizenship (Maretlly, 2011) was critical but needs to be expanded (Zéphir, 2004). This investment is not just a question of capital; reengaging Haitian youth in diaspora

through a type of Birthright program was invaluable to Israeli policy and would be valuable to us. Studies of diaspora migration yield a durable pattern of either reclamation or interference (Newland, 2004) According to the CFIC briefing, Haiti must shore up their massive brain drain (80% of degree holding Haitians living abroad). Critical studies of diaspora mobilization policy convince us of the critical need to empower, not simply extract remittance support (Newland, 2004). The Haitian Hometown Associations Resource Group (HHTARG) is government-sponsored effort to focus the Haitian Diaspora to invest back in the nation. Haitian American Caucus has done strong work in mobilizing the diaspora to be increasingly relevant in U.S. regional politics and channel direct aid into Haitian CBOs and should be empowered to increase their reach. Diaspora mobilization is key ingredient to national stability (Fitzduff, 2014).

The current ratio of physicians to patients 1 to 10,000 in cities/ 1 to 20,000 in the rural interior (WHO, 2014). According to the Ministry of Public Health and Population, the cholera epidemic had caused the deaths of 8,570 persons and infected 705,084 as at 20 July, 2014. Over 140,000 are living with HIV (UNAIDS/PAHO, 2014). There remain upwards of 103,565 earthquake IDPs living in squalor (Farmer, 2014). Lacking resources our governmental capacity has remained dependent on foreign medical NGOS. Following the existing polices of Dr. Farmer and the ZL-PIH in Health policy; he has recommended and implemented with the new University Hospital of Mirabalais an approach to patient care that empowers Haitian citizens through direct teaching hospitals and poly clinics. The ZL-PIH policies recommend; a) utilization of community health workers trained in all communities; b) focus on medical outposts in rural areas to extend basic coverage; c) establishing continuing education and training at each site d) combining public health, public education and 'preferential options for the poor' (Farmer, 2001). Other successful polices have included those of Bernard Mevs-University of Miami collaborating between facilities with teaching hospitals abroad. Diplomatic policy with the governments of Spain, Brazil, Venezuela & Cuba have over 700 Cuban MDs and RNs serving in all departments; and 1,200 Haitian medical students training in Havana (CMB, 2014). Cuba recently initiated its French language medical school at ELAM and can absorb an increased number of our candidate students. Haitian national ambulance service is not yet operational in the capital (HERO, 2014). Extensive studies of Cuban health delivery support integrated track health systems (Feinsilver, 2010.) This means removing barriers of entry from one medical rank to the next, preventing brain drain by educating in country and offering better salaries for axillary health professions.

On 17 April 2013 MIT and Haiti ratified an initiative that will help develop Haitian Kreyòl-language education in the science, technology, engineering and math (STEM) disciplines, part of an effort to help Haitians learn in the language most of them speak at home (95%). The

current government is openly invested in use of Haitian Kreyòl to empower youth to meaningful education. Currently we utilize an out dated French language national testing system although only 1/3 of our facilities are monitored by the Education ministry. On Vocational Capacity and skill building; BRAC International which is currently giving technical training to *Fonkoze* their largest (although questionably successful) micro-creditor has a range of paraprofessional services that might be developed in Haiti (Smillie, 2009)(BRAC, 2012).

Deforestation remains at a shocking 93% due to the use of charcoal as an energy and cooking fuel (UNDP, 2014). Aggressive replanting must be coupled with alternative energy promotion and Disaster Risk Reduction (DRR). Energy, re-forestation, and DRR must be mutually reinforcing activities. The Department of Civil Protection (DCP) must integrate DRR into renewable energy promotion (Dolisca, 2007). Sporadic investment in t-shelter construction and NGO green energy campaigns have not culminated in sustainable programs because of previously stated NGO mismanagement creating a lack long term coordination (Schwartz, 2014). Policies to expand electrification are necessary throughout the country. Outside the capital national grid power lasts barely three hours daily and is often completely lacking in the rural interior. Solar lighting must be expanded. Environmental degradation should not be linked purely to the preservation of a tourism sector; it needs to serve the immediate aim of social welfare (Schuller, 2012). Garbage collection is almost non-existent and public burning of trash in a wide spread practice. MIT Poverty Lab has pioneered a series of randomized control trials we must apply to all NGO and governmental initiatives as well as systems of humanure/ bio waste energy schemes that they must adopt, such as those of *Sanergy*. Previous policies to modal tourism and environmental preservation have only created the illusion of progress and several small tourist ghettos akin to what exists abundantly in the Dominican Republic, albeit far more insulated from the glowering face of miserable poverty.

The Institute for Justice & Democracy in Haiti has recently unsuccessfully sued the UN in relation to the Cholera epidemic. At current time the Center for Disease Control USA, Duke University and the Health Ministry of Cuba have all independently confirmed the high probability of Nepalese MINUSTAH peacekeepers as the source. These foreign troops are increasingly unpopular and source of great ongoing unrest. With just over 10,000 Haitian National Police and no military, they cannot rationally secure their territory or contain the recent reemergence of Lavalas protest disruptions, G184 paramilitary reprisals or expansive narco-trafficking. U.S. government officials have declared that 83 metric tons or 8% of the cocaine entering the United States in 2006 transited either Haiti or the Dominican Republic via freighters bound for Miami (Institute for Peace, 2007)(Whitney, 1996). The August 2014 prison

break in Croix-des-Bouquets illustrates the deep penetration paramilitaries into their existing state security formations.

It is believed by Human Rights Watch that 70,000 documented and 1.93 million undocumented Haitians are residing inside the Dominican Republic. In 2013 the Dominican Republic Constitutional Court ruled that any children born in country, on Dominican territory since 1929 to foreigners, were effectively denationalized. Affecting over 458,233 Haitians working in DR, this law has left an estimated 200,000 people stateless. Violent anti-Haitian pogroms are being sporadically reported and the two nations have broken official diplomatic contact. There are still upwards of 250,000 *Restavek* child slaves used throughout the country (CIA, 2014). This as long as it continues will remain one of the purest reminders of their humiliation in claiming the victory of their initial slave uprising, ingrained forever in the national ethos and identity.

Methods

An extensive literature review and data analysis was conducted using multiple sources to verify the effectiveness of the interventions profiled in the case study cited, i.e. methodologies of Eastern/ Southern development. I will utilize reports by multilateral agencies such as the United Nations, Pan American Health Organization, World Health Organization, the World Bank and BRICS/New Development Bank; government reports; published literature and essays; published research papers on mass capacity interventions; and standardized, informal interviews with government officials, local and international NGOs affiliated with past and/or current projects in the Republics of Haiti and Cuba, and with staff of the Haitian American Caucus, Cuban Medical Brigades and the four divisions of the Haitian Emergency Group; *Gwoup Ayisyen pou Ijans*-(G.A.I.).

In evaluation of the modular based training of 104 EMTs in the Republic of Haiti conducted by the multi-sector stakeholder alliance called *Rezo Medikal Ayisyen* / Haitian Medical Network;

I will rely on the logical framework modals, monitoring & evaluation documentation, field reports and direct informal interviews with the numerous student participants, officers and respective leaderships as well as stake holders that supported the five year effort.

A three-month cycle period is necessary to achieve a comparable level of training to an American National Registry standard Emergency Medical Technician-Basic (EMT-B). This course met 4-5 days a week, 5 hours a day not including 24 mandatory off site clinical rotation hours.

246 total Class Hours
144 hours didactic instruction
96 hours practical skills training
24 hours of clinical site training
6 in final drills & testing

Each module began with a skills intensive two week Community First Responder training using National Registry CFR materials. There were then eight days of Community Health Worker training based on Partners in Health (PIH) Standards. The course then continued with a rigorous mix of EMT-Basic didactic instruction in local language of instruction via power points, illustrated diagrams and exams; with weekly multiple choice testing, homework assignments, practical scenario drills and clinical field rotations at a local hospital.

All students have passed a final 200 question written exam and seven-station practical examination under the supervision of previously certified Haitian EMTs and an MSPP recognized MD, these are the exact standards American EMTs are held to. Our four trials had several program and deployment adjustments, but each gradated Haitian EMTs that have all proven to meet the best practice standards of their US equivalents.

With ideal resources and logistical support this program would continue in a total of four classes (module generations) back to back every three months to generate a possible total of 160 EMT health workers, an indigenous instructor corps, a fully localized module and an operational emergency group.

The preferred number of sponsored course generations is four classes of three months each training 40 students at a time along with an instructor corps. Recommended ratio of instructors to students is 5 to 40. Two non-indigenous local language proficient EMS personnel preferably one paramedic and one EMT. Two local personnel serving as instructors preferably with some medical background. One educational administrator (teacher) tasked with improving the module over the four generations into most replicable indigenous form. Over the course of the four project cycles non-indigenous personnel are systematically withdrawn until the

replication should be possible by class four almost entirely directed by the cultivated local instructor corps.

Practical Skills Competences

Over the course of the three month program candidates gained competency in the following (16) practical skills. To complete their training candidates tested out in (7) Scenario Stations which will demonstrate competency in all (16) skills.

Medical Documentation
Public Health Monitoring
Patient Assessment Medical
Patient Assessment Trauma
Rapid Trauma Extrication
Pupil reaction, blood pressure,
Heart rate, Respiratory rate, Lung sounds
Cardiopulmonary resuscitation (CPR)
Use of Automated External Defibrillator (AED) device
Seated, Standing, Supine spinal immobilizations
Bleeding control/ bandaging/ wound care
NPA/OPA/Suction Airway control
Splinting long and short bones
Lifting and Carrying
Ventilation and O2 administration
MCI management/triage
Neonate Delivery

Practical Skills Testing Stations

Students were signed off on these skills over the course. They will be tested out on each of them during a scheduled **FINAL PRACTICAL EXAMINATION.**

1. Patient Assessment Medical
2. Patient Assessment Trauma
3. Manual Airway Ventilation/ Oxygen Therapy
4. Cardio-pulmonary resuscitation (CPR) w. (AED) device & manual ventilation
5. Supine Spinal immobilization

6. Bleeding control & shock management
7. Splinting long and short bones

Written Examinations

Candidates took weekly written examinations in local language of 25-50 multiple-choice questions and (3) Section Exams of 100 multiple-choice questions (Medical, Trauma, Advanced Operations). Weekly homework projects and group work emphasized aspects of classroom instruction while enhancing the module with indigenous knowledge. There was a 200 question final written exam at the summation of the course.

All students were expected to maintain a 70% cumulative average throughout the course to be eligible for the EMT title. Students with below 70 % average that demonstrated full practical skill competency tested out for the titles Community First Responder, Advanced First Responder and Community Health Worker. The objective of testing is viewed as a tool to enhance retention of knowledge and ensure quality control. It was expected based on advanced screening that 35 of 40 will graduate as EMTs and 5 will graduate on the lower level as CFRs as would be expected under best practices of an American class environment. A maximal graduation rate is of course desired but as these are students being held to the highest quality standards to save lives and deal with the poorest of the poor, the sick and the injured; they will be asked to meet the international standards necessary to maintain the integrity of the new service.

It was viewed that the graduation rates were too high in both EMPACT Northwest classes; nearly 100% which is not normal for a typical EMT class. This was a result we deduced of their system of rotating in two American instructors every one to two weeks which enabled there to be limited connection between instructor and students. However, most EMPACT students were bi-lingual and EMPACT utilized text books while Banshee did not. Banshee graduation overall rates are higher in number, but GAI and RMA students that didn't pass the written tests were retained as advanced first responders.

Syllabus

This syllabus constitutes a National Registry standard Emergency Health Care Provider EMT-B Course covered in the first three months of training based upon Mosby, AAOS and Brady EMT course books.

Section One: Medical

Introduction to EMS
Wellness & Safety
Medical Legal Ethics
Anatomy and Physiology Pt. 1
Anatomy and Physiology Pt. 2
Vital Signs
Lifting & Carrying
Airway Control
Patient Assessment
Tactical Communications
General Pharmacology
Respiratory Emergencies
Cardiovascular Emergencies
Neurological Emergencies
Abdominal Emergencies
Diabetic Emergencies
Anaphylactic Emergencies
Substance Abuse & Toxicology
Environmental Emergencies
Behavioral Emergencies
OB GYN
Pediatrics
Pediatric Assessment
Geriatric
Geriatric Assessment

Section Two: Trauma
Kinetics of Trauma
Bleeding
Shock
Soft tissue injuries
Eye, Ear, Nose
Face & Throat
Chest Injuries
Abdominal and Genital Injuries
Musculoskeletal Injuries

Head/ Spine Injuries
Mass Casualty Incidents
Tactical Combat Medicine

Section Three: Advanced Operations

Ambulance Operations
Vehicle Extrication
Special Operations
Structures of Command, Control and Response
Multiagency Interface
National Incident Command System
START Triage System
Intro to Advanced Airways
Intro to IVs
Intro to Cardiac Monitors
Wilderness Medicine
Supply Improvisation/ Manufacture
Local Epidemiology
Ethnomedicine[18]
Public Health & Human Rights

Ongoing Scope of Volunteer Deployment and EMS Training Efforts in Haiti

Drafted December, 10th, 2011 (renewed 1 Jan, 2015)
Micro-brief on the Training of Haitian Emergency Medical Personnel

1. PURPOSE

1.1 To set forth policy and procedures for the ongoing training an emergency medical service in Port Au Prince, Haiti.

2. SCOPE

[18] Ethnomedicine is the study, understanding and incorporation of biomedical practice alongside indigenous traditional medicine practices particular to a given nation.

2.1 These procedures apply to all medical volunteers under the RMA Alliance Deployment Command, all Haitian medical cadets seeking recognition as EMT-Basics via the training program, and all American, Haitian, and International agencies both NGO and governmental which via mutual aid and alliance support this training program.

3. DURATION

3.1 The commencement of the renewed deployment will begin on the morning of January 4th, 2011 and extend until March 30th, 2015. It will be followed by waves of medical volunteers January 1st, 2011 through December of 2014.
3.2 It will consist of numerous sub-deployments. Some designated NEGOTIATIONS. Some designated TRAINING.
3.3 This period will be considered the 2nd ALLIANCE WAVE. (Wave 01 being the various earthquake response deployments)
3.4 This program will be extended into subsequent waves based upon successful completion of operations and adequate staffing.

4. DEFINITIONS

4.1 **Gwoup Ayisyen pou Ijans (GAI):** All Haitian national force of roughly 125 male and female civilian volunteers enlisted from Church groups, the Haitian Scouts, and the University Hospital's formerly operational medical school. Trained originally by AMHE-Bedstuy Volunteer Ambulance Corps volunteers operating in the first few days of the earthquake relief operations, received further training from Canadian Red Cross and Israel Aid. This force is to be the nucleus of an Emergency Medical System for the country of Haiti, controlled exclusively by the Haitian people. We began training 64 cadets on January 10th, 2010. There are now 25 EMTs and 100 CFR capable students thanks to our last wave's training initiative which ran until July 2011.
To be responsible for spearheading the GAI training operations, housing EMS volunteers coming to Haiti; provide a base of operations in Central PAP for training, stockpiling equipment, and coordinating various EMS training and deployment efforts into a centralized system.
4.2 **RMA Alliance02:** New York based network responsible for orientating volunteers in the USA, ensuring standardized levels of training and readiness before deployment; negotiating between factions, NGOs, grassroots groups and the Haitian government; serving as a clearing house for volunteer needs on the island of Haiti-and debriefing in New York.

All groups, organizations, NFPs, NGOs and governmental agencies that support our dual objectives of:

a) Establishing an Emergency Medical Service in the country of Haiti.
b) The Advancement of Human Rights & Self-Determinism for the Haitian people.

Basis for membership in Alliance01 is based upon a commitment to Universal Human Rights, material-financial support for the G.A.I. & other Haitian controlled groups advancing their people's condition; commitment to education-awareness on the plight of the Haitian people, and or the commitment of human resources via the sending of medical, instructional, and developmental volunteers to the Country of Haiti.

4.3 **Banshee Association**: EMS Fraternal Organization responsible for recruiting and training Medical and Rescue personnel in the US; acquiring and modifying EMS training materials for use and instruction in the French & Creole Languages (Based on international norms of BLS curriculum standards with the approval of Haitian government); establishing Medical-Instructional squads for deployment in Haiti to train, supply, and serve alongside in the field with the G.A.I. (GWOUP AYISYEN pou IJANS/Haitian Emergency Group).

4.4 **First Wave:** The irregular medical deployment of tens of thousands of civilian aid works that via their own means self-deployed to Haiti form around the world in the days immediately following the earthquake which occurred on January 12th, 2010 killing approximately 300,000 people. The response of recognized international bodies, governmental agencies and international NGOs that assumed official control of the relief effort by week 3 of the response.

4.5 **Second Wave:** The redeployment on January 10th, 2011 of civilian volunteers lead by the Haitian Diaspora to restore infrastructure, support relief organizations and train the GAI as Haiti's first professional EMS corps. This latest effort will constitute our fourth wave.

4.6 **Volunteer Conduit:** The pipeline established concerning the recruitment, orientation, procurement of necessary provisions, deployment and extraction of volunteer personnel to the Island of Haiti. This pipeline serves to ensure effective transfer of supplies between the United States and Haiti, the safety and security of our civilian personnel and the debriefing, critical stress management and continued medical follow-up of volunteers post deployment.

4.7 **Staggered Wave Deployment:** The training and enlistment of civilian medical workers, professional EMS in the USA, and unpaid civilian volunteers to deploy as a reservist relief force in one week sub-deployments.

4.8 **Coordinator:** Part-time unpaid coordinators in Port Au Prince and New York City that handle the corporate, NGO aspects of the VOLUNTEER CONDUIT.
4.9 **Case Officer:** Part time unpaid volunteers that serve in Working Groups (Medical Instructional, Supplies & Logistics, and Media handling cases, or specific projects.

4.10 **Volunteer**: Unpaid civilians deploying to Port Au Prince Haiti to facilitate the training of GAI and its deployment via clinical rotations in Port Au Prince.

5. VOLUNTEER POLICY

5.1 No coordinator, case officer, or volunteer operating under the RMA Alliance Deployment Command shall receive monetary compensation for their efforts.
5.2 All coordinators, case officers and volunteers are to have read the DEPLOYMENT MANUAL, adhere to its protocols and guidelines and follow the direct commands of its appointed leaders.
5.3 All coordinators, case officers and volunteers must sign the Alliance Waiver of Liability.
5.4 All coordinators, case officers and volunteers must attend the 6 hour mandatory orientation prior to deployment.
5.5 All coordinators, case officers and volunteers must personally cover their own airfare to Port Au Prince, Haiti. We can assist you in coordinating direct sponsorship via our SPONSOR A RESCUER PROGRAM.
5.6 All coordinators, case officers and volunteers must obtain the equipment necessary to perform their role in the training of GAI.
5.7 All coordinators, case officers and volunteers must remain in multi-form while deployed in the field. Multi-form consists on blue BDU pants, black boots, a blue/black shirt and or a blue BDU button down shirt. No insignia are permitted than that of your medical rank (i.e. Street Medic, CRF, EMT, RN, LPN, MD). NO NGO/ Political/ National patches are permitted.
5.8 All coordinators, case officers and volunteers must make every effort to obtain the recommended vaccinations prior to deployment.
5.9 All coordinators, case officers and volunteers must refrain from any commentary to the press mainstream or otherwise without direct authorization of the ALLIANCE PRESS BUREAU/Media Working Group.
5.10 All coordinators, case officers and volunteers must commit to a seven day deployment within the timeframe of the wave and its four sub-deployments.

5.11 No coordinators, case officers and volunteers will be allowed to extend their deployment and deployment shall exceed the length of two weeks.
5.12 No coordinators, case officers and volunteers will be authorized to spread religious or political ideology while serving under the deployment command.
5.13 All coordinators, case officers and volunteers serving in a municipal capacity must have the authorization of their employer to participate in this operation.
5.14 All volunteers must make every effort to learn Creole or French, or both.

6. GAI TRAINING POLICY

6.1 GAI will supply us with a list of ALL EMT candidates who formed the student body of the GAI HAITIAN EMS CADET CLASS 0001 and subsequent classes. We must continue to evaluate their ability to pass the 8 EMS Practical skills and complete French language written exam.
6.2 Members of GAI will set up regular drills, meetings and salons.
6.3 Members of GAI will be supplied with further equipment once their skills have been evaluated.
6.4 Members of GAI will be broken into 8 squads of 8 with a selected squad leader. They will remain in these squads for duration of their training and clinical rotations.
6.5 GAI students will be assigned medical instructor to overseeing their training at any given time.
6.6 GAI students will be engaged in clinical rotations at medical outposts and hospitals throughout Port Au Prince and will attend regular lecture and drill.
6.7 The training/ operational day for rotations will be divided into three shifts called Tours 1 (midnight) Tour 2 (Day) and Tour 3 (Evening).
6.8 There will be 4 platoons A, B, C, and D. We will divide the platoons based upon location and scheduling.
6.9 Each GAI training squad will ideally be assigned at least two Creole Speaking Medical Training volunteers certified in the USA as CFR-D, EMT, EMT-P, RN, or MD.
6.10. Alliance 01 and GAI will document and set up meetings with all medical receiving outposts in greater Port Au Prince.
6.11 Clinical Rotations are to be conducted at fixed locations.
6.12 Lecture and Drill are to be conducted a set base.
6.13 GAI Cadets are to establish a quarter master, and cache point for equipment.
6.14 GAI Cadets are to be registered with the MSPP and continually prepared for official testing.
6.15 As each week long sub-deployment is relieved, the subsequent medical training squad of volunteers is to be fully briefed on the progress of each cadet. At the end of each week practical skills test rehearsals will be given.

6.16 Ideally on the final week of the deployment in the end of March each GAI cadet is to be certified as an EMT, as per a future negotiation with the health ministry.
6.17 Subsequent waves will seek to make more GAI students capable of passing a French language BLS exam, recognized by the MSPP.
6.18 All equipment to be issued to GAI must be accounted for and properly secured.
6.19 Ideally each GAI Cadet will receive a certificate, a blood pressure cuff, a stethoscope, and a pair of sheers.
6.20 DRILL will cover patient assessment medical, patient assessment trauma, airway-AED-CPR, wound care and bandaging, splinting, spinal immobilization, *no* application of KED, OB-GYN labor and delivery, and be taught via scenario hands on drill.
6.21 LECTURE will cover a topical overview of all BLS material broken into segments with French language lectures to be projected on a screen.
6.22 All printed course materials are to be in FRENCH and HAITIAN CREOLE. All tests will be in FRENCH.
6.23 All Clinical rotations will occur at established clinics, hospital and medical outposts.
6.24 GAI IS TO BE CONSULTED ON EVERY OPERATIONAL DECISION.
6.25 NO OPERATIONAL OR PROCEDURAL CHANGES WILL OCCUR WITHOUT GAI APPROVAL.
6.26 NO NGOs OR ANY BODY CONTRARY TO THE INTERESTS OF THE HAITIAN PEOPLE WILL BE INCLUDED IN ANY LEVEL OF THE ALLIANCE01 in HAITI OR ABROAD.
6.27 GAI are to regularly screen and assess their members individually for skills competency, ethical practice, and dedication to the cause of establishing a Haitian EMS system.
6.28 Alliance02 are to regularly screen their volunteers individually for skills competency, ethical practice, and dedication to the advancement of Human Rights in Haiti.

Output Indicators

1. Attendance reports
2. Test and Exam scores
3. Final Examination scores
4. # of Community First Responders trained. (class/total)
5. # of EMT-Bs trained. (class/total)
6. Number of program graduates employed post-graduation in medical or teaching capacities at local facilities/ agencies.
7. Number of program graduates employed via CBO agencies.
8. Number of new operational Civil Service Enterprise units chartered and registered.

Impact Indicators

1. Evaluators report popular support and use of EMS services.
2. Existing medical provision agencies hiring statistics.
3. # of Emergency Calls responded to by graduating members.
4. Diaspora funding for the Civil Service Enterprise (CSE).
5. Political support, legal recognition of CSE.
6. Indigenous replication of module
7. Recertification tests three years later
8. Quality Improvement/ Quality control reporting

Literature Review

My research work in building the module is being driven by development programs initiated in the Global South & Periphery[19], but the theoretical construct is Eastern in origin. It was in Russia and China that major, albeit authoritarian and economically unstable alternatives to free market monopoly capitalist development achieved unparalleled needs and rights advances for hundreds of millions of people, despite how modern revisionist history would like to re-interpret these events. Prior to the Communist revolutions of 1917 (Russia), China (1949) and Cuba (1959) all non-European insurgencies opposing the colonial economic order had been nationalists seeking market economies. The advent of Revolutionary Socialism and the bipolar super power confrontation of the Cold War period was the first time since 1500ce that subjugated, developing nations had competing alternatives to the world order being exported by Europe and the United States (Wallerstein, 1991). It was during this period of free market-command economy confrontation that more humans perished than any other time in previous history, greater even than the cumulative toll of the World Wars immediately preceding. My module research is based on successful methodology of alter-development pioneered in this period to lay the theoretical foundations for the establishment of the emergency group in Haiti in 2010.

The world in 2015 is now divided into 193 U.N. recognized, 206 officially designated economic, quasi-national zones. While it would be largely accurate to state that the core of the world system lies in the global North and West; it would be wildly inaccurate to think this is a static reality. There are multipolar challenges coming from the People's Republic of China, the Russian Federation and India. There are a myriad of shifting paradigms in development methodology. Particularly those activities occurring in Cuba, Bangladesh, but also in New York, India, Israel and Iran. While this may seem a highly global, but irregular data set; the following findings are emerging that will revolutionize the modern system of indigenous development capacity building. To transform the enterprise completely from one, which focuses on barely meeting human needs to one that generates human rights achievement via mass capacity. From Cuba we have seen some of the largest medical deployments in human history; an estimated 50,000 medical workers and comparable number of teachers and construction workers (Feinsilver, 1993). A full 6% of Cuba's GDP is generated providing healthcare, education and construction of infrastructure to the developing world. Its population is 99% literate and has better health indicators than the United States. Bangladesh has facilitated the birth of the world's largest NGO BRAC. Over 102,281 people (BRAC, 2012) employed in a massive hybrid system

[19] The "Global South" is an erroneous term of Western Development misleadingly indicating that development can be spatially identified in a fixed geographic zone. Core, Semi-Periphery and Periphery as delineated in Wallerstien's World System Analysis better expresses the dynamic nature of these economic zones. Dynamic in relation to both geography and development.

that cover 70-80% of its own operational needs though social industries. That runs major businesses, micro creditors, schools, health services and paraprofessional training. The Acumen Fund in New York has set up over 82 major social enterprises in the global south through their implementation of patient capital. Israel has developed sophisticated training systems in health and agriculture to generate functional cohorts. Its state formation itself was a demonstration of parallel state development. Iran has made incredible progress through an innovative system of community health workers called the *Behvarzan*; it has also demonstrated via *Hezbollah* in Lebanon its ability to rapidly introduce Para State functionality and security in a war zone. Beginning in 2008 India via the Indian Skills Development Corporation has set out to provide vocational training to millions of it is citizens via a vast public-private partnership.

An extensive literature review and data analysis has been conducted using numerous sources to verify the effectiveness of the interventions profiled in the case studies cited, i.e. methodologies of Eastern/ Southern development. I will utilize reports by multilateral agencies such as the United Nations, Pan American Health Organization, World Health Organization, the World Bank, the World Social Forum, Alter-Development, Alter-Globalization[20] and BRICS/New Development Bank; government reports; published literature and essays; published research papers on mass capacity interventions; and standardized, informal interviews with government officials, local and international NGOs affiliated with past and/or current projects in the Republics of Haiti and Cuba, and with staff of the Haitian American Caucus, Partners in Health, Cuban Medical Brigades and the four divisions of the Haitian Emergency Group; *Gwoup Ayisyen pou Ijans*- (G.A.I.).

In evaluation of the modular based training of 104 EMTs/551 CFRS in the Republic of Haiti conducted by the multi-sector stakeholder alliance called *Rezo Medikal Ayisyen* / Haitian Medical Network; I will rely on the logical framework modals, monitoring, evaluation & learning (MEL) documentation, QED field reports[21] and direct informal interviews with the

[20] Alter-globalization —or the global justice movement is the name of federated social movements linked through the internet and World Social Forum whose activists support global cooperation and interaction, but resist the harmful effects of purely economic globalization, which has severe negative consequences for human rights, environmental sustainability, economic equity, indigenous peoples, labor protection, peace and civil liberties.

[21] Each of the four Haitian EMT trainings carried out between 2011-2015 were randomly assigned students based on a multiplicity of participating actors both NGO and local CBOs. Running simultaneously to each of the four classes, were three ideal control groups; Partners in Health's CHWs, St. Jeans First Aid program for police, & Die Johanitter's Franco-German implementation of CAN, the proposed national ambulance service. No participants were assigned to wither group, but both segments have been documented for three criteria. A) Pre-hospital medical utility, b) agency for upgrade to higher levels of training, c) independent employment in livelihoods with dignity. Based on these findings, based on cost effective analysis we advocate the module approach has far more impact than St. Jeans & Die Johanniter, but must be used in conjunction with Partners in Health CHW programs.

numerous EMT student participants, officers and respective leaderships as well as stake holders that supported the five year effort.

This is to help paint a portrait of the works of development theories the modules are founded in. Suffice to say the biggest critique of the Western development enterprise is that it breeds dependency; these mass capacity modules are the most cost effective tool to reestablish critical services that allow incremental, encroaching autonomy.

Five external organizations (ABCDE) in the contemporary four sectors (private, public, NGO, diaspora, & civil society) demonstrate several *hybrid capital development solutions* to economic dependency via ***Civil Service Enterprise*** all of which are sophisticated hybridized development modals not easily labeled by sector at all, but are modern sophisticated examples of Eastern development as applied Southern methodology, none of which are in antagonism with state actors. Studying these five groups have truly been where the conception of the module based training yielding civil service enterprises came from.

Praxis

Acumen Fund, based in New York and via their venture patient capital approach to seeding social enterprises (S/E) in the Global South they have enjoyed broad support from the Gates & Skoll Foundations and Acumen's intimate connection to TED Talks intellectual capital. They have successfully built 82 S/Es via investment of over $88 million throughout the developing world coupling private foreign investment with respect for indigenous knowledge and innovation. They maintain six robust portfolios of S/E in water, health, housing energy, agriculture and education committing between $300k-$2 million in equity or loan with payback or exit windows of 7-10 years. **Acumen is private capital intermediary for major Western foundations to channel funding and expertise to free market solutions for social problems throughout the developing world.** *This case was used to establish a template for core to periphery funding mechanisms that extend private capital through a non-for-profit intermediary into social enterprises abroad.*

BRAC, based in Dhaka, Bangladesh, the world's largest NGO couples microfinance, social enterprise, a retail handicrafts, food and dairy empire with holistic social programs, paraprofessional training and a university system emphasizing the human rights based approach. BRAC operates in 14 countries with over 102,218 paid employees while remaining 84% economically self-sufficient. **BRAC is a banking intuition & private university system,**

providing social services and social enterprise formation in 14 nations, while participating in major multilateral anti-poverty initiatives. *This case was used to demonstrate the functionalities of a large scale peripherally based and funded hybrid organization.* Smillie (2009) in *Freedom from want: The remarkable success story of BRAC, the global grassroots organization that's winning the fight against poverty*. Outlines the basics of the BRAC modal. Halder, S. R., & Mosley, P. (2004). Working with the ultra-poor: learning from BRAC experiences. *Journal of International Development*, *16*(3), 387-406. This explains their targeting the ultra-poor programs.

Cuban International Medical Brigades; with development aid and direct technical services composing 40-60% of the Cuban GDP via export of development services and training in health, education and infrastructure. The Cubans have over 50,000 medical professionals working in over 47 countries as well as extensive capability in training developing world populations in medicine, science, education and other needed socially beneficial trades. They are also operate the world's largest free Medical school ELAM which annually trains over 10,000 nationals of developing nations/ communities in medicine. **CIMB is a government funded foreign policy of using medical capacity development to project soft power and win allies using medicine not arms.** *This care will be used to showcase the viability of development technology export as a viable component of both GDP and soft power.* Kirk, J. M., & Erisman, H. M. (2009) in *Cuban Medical Internationalism.* Outline the full extend of Cuban medical aid programs and the significance of medical internationalism. *Healing the Masses: Cuban health politics at home and abroad.* & Huish, R. (2008). Going where no doctor has gone before: The Role of Cuba's Latin American School of Medicine in meeting the needs of some of the world's most vulnerable populations. *Public health*, *122*(6), 552-557. Ryan (1978) in *The Organization of Soviet Medical Care.* Gives us a look into Soviet style medical development.

Indian Skill Development Corporation: Begun in 2008 this private-public partnership lead by the Indian government aims to provide mass capacity vocational training in 23 vocational sectors to 150 million Indians by 2020. It will be one of the largest historical attempts to systematically up-skill, re-train an indigenous national population. **This is a major government funded state enterprise to create domestic mass capacity in India.** *This case will bring attention to the largest instance of mass capacity building in human history.*

The World Zionist Organization (WZO): was originally founded as the **Zionist Organization** (**ZO**; 1897-1960) under the leadership of Theodor Herzl at the "First Zionist Congress", which took place in August 1897 in Basel, Switzerland. The goals of the Zionist movement were stated in a resolution that came of that Congress and came to be known as the

"Basel Program." Quote from draft program; *"Zionism aims at establishing for the Jewish people a legally assured home in Palestine. For the attainment of this purpose, the Congress considers the following means serviceable:*

> *(1) the promotion of the settlement of Jewish agriculturists [farmers], artisans, and tradesmen in Palestine; (2) the federation [unified organization] of all Jews into local or general groups, according to the laws of the various countries; (3) the strengthening of the Jewish feeling and consciousness [national sentiment and national consciousness]; (4) preparatory steps for the attainment of those governmental grants which are necessary to the achievement of the Zionist purpose."."*

The Zionist experiments in state building, divorced from the long running and intractable conflict in Palestine is one of the most interesting examples of Diaspora led national construction. Piece meal the Zionist development tool laid a functional piece of a future state and then claimed in.

Theory

Brazilian Development minister Roberto Unger writes on False Necessity or Anti-Necessitarian thinking describing the consequences of belief in a "Closed list of structures", where by future econ-political arrangements might be possible outside of the socialist/ capitalist framework. His "illusion of indivisibility" posits that indivisible systems do not exist in reality that must wholly replace each other. Practical consequences mean that hybrid systems can exist, new systems can be created. Most importantly, experiments should always be undertaken with hybrid systems in existing states of social service market failure.

Swiss post development theorist Gilbert Rist in (2003) wrote *The History of Development: From Western Origins to Global Faith,* in which he systematically traces the un-measurable, amorphous global phenomenon called 'development' and its evolving manifestations. This work lucidly evaluates the history of the development enterprise and its grand utility in East v. West; North to South projection of political influence and economic power (p. 72). Although categorized as post development analysis, many of his critiques are important in establishing thought and praxis continuity in the general evolution of the discourse. Alongside Unger what is presented is an attack on treatments that try and avoid confronting failed systems of distribution.

American Sociologist Immanuel Wallerstein (1974) wrote *The Modern World-System I: capitalist agriculture and the origins of the European world-economy in the sixteenth century*. In three subsequent volumes (2-4) Wallerstein traces the rise of the Modern World System and the shift of Core dominance from Netherlands to England; and then to the United States. He identifies in detail a global system of core, semi-periphery and peripheral national units with interlocking economic relationships of hegemony and subordination (v.1, p.224). After examining the triumph of liberalism following the World Wars with Germany and the Cold War with the USSR; Wallerstein (2012) asks the question in his latest works *Uncertain Worlds: World-Systems analysis in changing times* what will Core Shift to China and BRIC powers mean for the World System, and in (2013); *Does Capitalism have a future?* As such a toll on humanity and planet has been taken so unsustainably under this 500 year old economic order; Multipolarity is inevitable, but neoliberalism and capitalism as currently implemented are not (p.86).

What makes Wallerstien interesting is that during the upcoming period of 'core shift' to China there will be a huge period of realignment of mode of production and means of development. I find the BRICS to be a likely source of support for development tools such as ours that are geared to local empowerment via up-skilling workers. Wallerstein creates one of the most effective mapping systems of showing how wealth is accumulated structurally.

The French economist Thomas Piketty in 2014 wrote, *Capital in the 21st Century*; which argues that elite wealth accumulations are accelerating and threatening to both democracy and global order. He argues that at no other time in history have so few individuals managed to concentrate so much wealth as a result of the rate of return on capital being far greater than the return on growth over an extended period; thus causing social instability. His solution of progressive wealth taxes is unrealistic and caters to the illusion of the liberal petty bourgeoisie. Lessig (2011) *Republic, Lost: how money corrupts Congress--and a plan to stop it* explains legislative capture in an American context (p. 91).

Anderson (1983) in *Imagined Communities: Reflections on the Origin and Spread of Nationalism;* deeply explores the socio-psychological construct of nationalism asserting all nationalisms to be a politically created invention for the purpose of economic control (p. 84). Gellner (1983) in *Nations and Nationalism* writes that nations are political units forged during the industrial revolution to meet its demands for homogeneity of identity among the labor force and increase their productivity (p.72). I understand the modules as being structural planks in a parallel state; one that piece meal places functions of the nation back into play.

1776, the year that United States of America came into being as new nation; Scottish economist Adam Smith published *An Inquiry into the Nature and Causes of the Wealth of Nations*; the world's first collected treatise detailing that which builds national wealth, and how individual interest is guided via the invisible hand of the market to produce a collective social

good (p.456). Reflecting on the European economy prior to the Industrial Revolution, the book outlines the basis for what would become the classical economic foundation for the rise of the West. Modern capitalist economics of growth, market structure and development have been built on his ideas. As well as those of David Ricardo's ideas on free trade and *theory of comparative advantage*; Sir John Maynard Keynes's macroeconomic polies for government economic policy involving state intervention to mitigate effects of recession and depression (Maeir, p. 432). Milton Friedman later introduced sequential sampling statistics, monetarism (regulation of currency supplies to curtail inflation) and via the Chicago School was the intellectual father of Neoliberalism and structural adjustment.

American economist and political adviser Walt Rostow in (1960) wrote *The Stages of Economic Growth: A non-communist manifesto,* reducing development to five stages; traditional, pre-conditions for take-off, take-off, drive to maturity and high mass consumption, (p.59). His writings became the basis for Western Modernization Theory that dominated the Euro-American development discourse alongside trade and macroeconomic policies of Neoliberalism. In (1953) the *Methodology of Positive Economics,* he advocated that *"economics as science should be free of value judgments for it to be objective. Moreover, a useful economic theory should be judged not by its descriptive realism but by its simplicity and fruitfulness as an engine of prediction." (p.15)*

American Geographer and popular scientist Jared Diamond in (1997) wrote the book *Guns, Germs, and Steel*; which suggests that acquired immunological resistance to disease, superior weapons technology and advanced transport logistics allowed Eurasians to dominate the rest of the world's civilizations, a positive feed-back loop of developments. This *environmental determinism*, delinked from any notions of genetic or cultural superiority advances the idea as popular science that the geography of civilizations enabled the three advances necessary for widespread conquest. In his (2005) book *Collapse* he categorizes historical factors of civilization collapse outside of military conquest and economic system collapse. Those factors include; climate change, belligerent neighbors, collapse of vital trading partners, environmental catastrophe and failure to adapt to recurrent environment issues. He links modern threats of collapse to; habitat destruction, erosion, salinization, loss of soil fertility (degradation), water resource management, over hunting, species invasion, per-capita human impact, energy shortages and general over population. Economist Paul Collier in the *Bottom Billion* identifies 59 [22] underdeveloped, non-developing nations to make a case for good governance and intuitions.

[22] 58 were identified in his subsequent book, 59 as result of South Sudan's independence from the Islamic Republic of Sudan in 2012.

Canadian Evolutionary Psychologist Steven Pinker in (2011) in *The better angels of our nature: Why violence has declined;* puts forward the argument, backed by 'hard data' that human violence is decreasing to the lowest point ever in history. This can be contrasted with several longitudinal studies of war, genocide and democide since 1900 that suggest Pinker's tome to cautious optimism is a) based on data that was unavailable before the 19th century (Foucault, 1966), b) fails to consider poverty related death as a structural violence and doesn't treat the World Wars and Cold Wars as related events (Rummel, 1998), disaggregating them into a series of unrelated national conflicts (Brzezinski, 2010). All of whom tabulate the death tolls of the 20th century to be somewhere in approximation of 9% of the human species eradicated violently via wars and related effects between 1900-1945; and an even greater toll, with a body count three times as high was accumulated in the 1945-1989 period of Cold War conflict. In the period between 1989-2015; there has been a rapid increase in non-state actor, low intensity violence and civil war (Kaldor, 2012).

British Political Scientist Mary Kaldor, advocate of "Cosmopolitan Democracy" calls these *New Wars*, and attempts to diagnose them as empirically more barbaric, but much smaller in scale than conventional old wars. She makes no reference to the African World War of 1998, the Syrian Civil War of 2012, the Russian annexations and atrocities in Moldova, Georgia and Ukraine; or the rise of ISIS. Contrasted with William Blum, W. (2003). *Killing Hope: US military and CIA interventions since World War II,* Blum written one of the most extensive catalogues of military intelligence interventions on the affairs of foreign nations originating from the USA. Alongside Ambrose, S. E. (2010). *Rise to globalism: American foreign policy since 1938*, we see that most of Ms. Kaldor's New Wars are the legacy of KGB/CIA activity and the U.S.-NATO military proxy confrontation with the USSR-Warsaw Pact during the Cold War period of 1945-1989.

Acemoglu, Robinson, & Woren (2012) in *Why Nations fail: the origins of power, prosperity and poverty (Vol. 4)* attempts to trace development to an issue of strong intuitions and governance. But, how can development, especially human rights based approach to development or emancipatory development be accomplished when entrenched elites so overtly influence policy in failed and thriving states alike? (Pogge, 2007)(Easterly, 2010). *Voices of the Poor: Crying out for Change* was commissioned by the World Bank in 2000, very few people have read it cover to cover, but evident throughout it is the dissociated voice of the powerless calling out for help without ascribing blame, this is of course the narrative of Humanitarian Impertivism of Western Aid. Former Chief Economist of the World Bank Joseph Stiglitz (2002) in *Globalization and its Discontents*, wrote that IMF policies caused persistent low levels of development, if not maldevelopment in Sub-Saharan Africa. That the East Asian financial crisis;

the Argentine economic crisis as well as the total failure of Russia's conversion to democracy and normative market economy were the result of free market policies understood to result in failure. Specific policies criticized by Stiglitz include insistence on the privatization of state assets, mandated fiscal austerity, high interest rates, full trade liberalization, and the liberalization of capital markets; recommendations of the now discredited *Washington Consensus*.

In his seminal 2007 work *The Bottom Billion: Why the Poorest countries are failing and what can be done about it;* Paul Collier, English Economist puts forward four structural causes for long term under-development called poverty traps (all of them outside of North Western culpability); land locked, resource curse, bad neighbors and poor governance. In (2013) via *Exodus: How migration is changing our world,* he makes a roundabout apologist case for brain drain and lifeboat development.

American economist Jeffery Sachs (2006), the sharp mind that helped bring us Russia's failed transition to democracy and markets; and via the Earth Institute; the Potemkinesque Millennium Villages wrote *The End of poverty: Economic Possibilities for our Time*; squared off with other Western development economists and posited that a big push, Marshall Plan type aid program could bring an end to extreme poverty throughout the developing world (p. 244). The response to this well read and recurved call to action came from William Easterly (2006) in *The White man's burden: why the West's efforts to aid the rest have done so much ill and so little good,* which introduced the bipolar development paradigm of planners and searchers; dismissively calling planners detached and utopian, and entrepreneurial searchers, relevant and receptive (p.. The two (Easterly and Sachs proceeded to then debate about which sector the OECD state system vie the UN (Sachs) or the private sector (Easterly) was best prepared to develop the developing world. Amartya Sen in (1999) wrote *Development as Freedom* which takes the Capabilities approach that development is means to achieve human rights and freedom, but the poorest of the poor must be empowered to do so by enhancing their agency and their skill set.

Serbian-American Branko Milanovic, formerly lead economist in the World Bank's research department in (2005) wrote *Worlds Apart: measuring international and global inequality* asking us to imagine a world without a middle class. His 2010 book *The Haves and the Have-Nots: A brief and idiosyncratic history of global inequality,* is a vain, pedantic distortion of social responsibility. In (2011) he wrote *Global Inequality: From class to location, from proletarians to migrants,* putting forth the argument that class warfare is no longer relevant in an age of globalization where increasingly migrants will travel rural to urban and south to North to radically increase their earning power.

Political Scientist Robert Rotberg in (2002) in *Failed States in a World of Terror* and *When States Fail: Causes and Consequences,* paints a lucid picture of the future of intra-state and civil warfare linked to protracted maldevelopment. Hochschild, A. (1999) in *King Leopold's Ghost: A story of greed, terror, and heroism in colonial Africa.* This detailed history of the Belgium Congo demonstrates the historic slaughter of the global south justified and carried out in the name of humanitarian imperative. Details the 1884-1885 Berlin Conference to divide Africa and the genocide of 5-20 million Congolese. Peter Uvins book *Aiding Violence,* Easterly's book *White Man's Burden* and Moyo, D. (2009). *Dead Aid: Why Aid Is Not Working and How There is Another Way for Africa* all provide graphic explanation of what a near total failure foreign aid has been to address deeply entrenched structural injustice and poverty. Assassinated Russian journalist Anna Politkovskaya in (2005) *Putin's Russia: Life in a Failing Democracy,* chronicles life in Russia after Euro-American economists introduced free-market capitalism. Cornell, S. & Jonsson, M. in (2014) via Conflict, Crime, and the State in Post-Communist Eurasia, explore the fruits of transition from Socialism to "democracy & free markets" in the former Soviet Union.

While neo-conservatives such as Samuel Huntington (1993) in *Clash of Civilizations* and Francis Fukuyama in (2006) *The End of History and the last man,* have attempted an ivory tower and public policy assault alongside those in the *Project for a New American Century;* the state of development is not about civilizational values, and world history certainly did not end with the fall of the Berlin Wall.

Marx & Engels (1848) wrote *The Communist Manifesto*; a call to arms for the international proletariat to wage armed struggle against the kings, aristocracy, and upper classes of society that they believed to be responsible for vast super structural inequality directly related to alienation and exploitation of labor (p. 34). In *Capital Volumes I* (1867), *&* posthumously by Engels *Volumes II* published in (1887) and *III in (1894)* Marx outlines an analysis of class struggle and economic dialectical relationships that have shaped human history. These writings, and the work of innumerous theorists & scholars who built upon them formed the body of revolutionary socialist development theory; a direct assault on the theories of Adam Smith and his many acolytes of the modern era particularly; John Maynard Keynes and Walt Rostow. It would not be fair to disclude the several dozen major Marxist, Socialist, Communist and Anarchist theoreticians that would come to write over the course of the 20th century; suffice to say that Proudhon, Bakunin, Kropotkin, Goldman, Luxembourg, Trotsky, Lenin, Mao, Nkrumah, Nyerere, Castro and Gutiérrez all expanded an ideological confrontation that regardless of tendency justified using violent insurgency to conquer 'the means of production'.

In 1971 Dennis Goulet, founder of Development-ethics in *Cruel Choice: A New Concept in Development Theory,* he outlined the precise implications of development as promoted by the

North West. In a bitter indictment of the development enterprise after the 1960-1970 U.N. declared *Decade of Development* he asks is development to be "ethical, or purely pragmatic economic-political decision making" (p. 301) and whether it is best to have development, or liberation (p. 314).

Eric Blair (1949) his seminal work *1984* outlines via literary fiction a world more similar to 2015 then many in the West accept. J. A. Winters (2011) in his book *Oligarchy* advances an explanation about a little known elite power structure grouping called 'Oligarical Collectivism' (p.20). Blair coined the phrase allegorically and 52 years later Winters wrote a historical study on the power dynamic of the phenomenon. It posits that ultra-wealthy monopoly capitalists direct national foreign policy destructively consolidating control. These Oligarch Collectives are regionally, linguistically linked through informal clubs and associations and have increasingly consolidated wealth into fewer and fewer hands through direct control of the financial architecture of the states they are based within (Winters, p. 211). H.J. Chang is his 2010 book *23 Things they don't tell you about Capitalism* identifies the structural contradictions, but more importantly the precise un-truths associated with free-market fundamentalism, policies that Oligarical Collectives in rich countries have never even utilized for their own economic growth (p.62). Legislative capture via these informal networks and campaign financing (in the West), deep structural cronyism (in Russia), Confucian autocracy aligned with hereditary access (China) and post-colonial opportunism and positioning had put all 206 nation state units at the disposal of powerful minority interests; particular those concentrated in New York, London, Beijing and Moscow.

Indian Marxist Vijay Prashad Vijay in (2013) wrote *The Poorer Nations: A possible history of the Global South*. In this sequel to his book *The Darker Nations,* which tracked the rise and demise of the non-aligned movement. This book imagines the Global South not as a place, but as the breeding ground for a variety of movements directed at breaking the hegemony of neoliberalism. Colombian anthropologist Arturo Escobar (1995) wrote *Encountering Development: The Making and Unmaking of the Third World* in which he declared that development as a socio-historic phenomena remained an exploitative political exercise, the architecture upon which the world economic system rests (p. 4). The "development apparatus" functions to support the consolidation of Euro-American hegemony, where the Bretton Woods intuitions and military force leave off. Often referred to in leftist and Alter-Globalization writings as 'neo-colonialism'; development remains and extractive enterprise at its core.

French-Algerian political philosopher Frantz Fanon in (1952) wrote *Black Skin, White Masks* analyzing the psychological harm inflicted by the colonial experience. In (1961) he wrote *The Wretched of the Earth* identifying that violence was completely justified in expunging

Euro-American influence from the developing world. Between 1945 and 2015, 120 new national entities would emerge from former colonies mostly through insurgency. While the specter of Cold War distorted the destiny of many of these new nations, all embraced development, Eastern or Western in asserting their claim to Non-Alignment. According to Chang, in *23 Things* those that resisted Western free market economist advice toward privatization, de-regulation and free trade (as most did in the period of 1950-1970) experienced far greater growth via either proto-socialism and protectionism that all of those (markedly in Latin American and Sub-Saharan African) that embraced free markets in the 1980's and had minimal or negative growth.

Tunisian Jewish Albert Memmi in (1957) wrote his seminal work on colonization; *The Colonizer and the Colonized*, argues that at the core of the colonial experience was a most mediocre migration of human capital traveling from the metropol to the colony which a) created the architecture of extractive dependency and b) fundamentally under-developed the colonizer and colonized in very different ways. The worst and most mediocre European managers cultivated predatory, backwards and dependent states.

French philosopher Michel Foucault (1966) *The Order of Things: An Archaeology of the human sciences* makes a very contrarian argument to all the 21st century best sellers crafted for the liberal elites noting that there is little evidence to suggest that numerically, demographically or structurally it was possible to have any record of deaths per capita, much less fashion some measurable recollection of human history. His underlying structuralist critique is that we do not have an objective basis to measure one episode of human history again another.

Egyptian Marxist *Samir Amin* provides us with a penetrating overview of how the colonial framework and its extractive dependences were transferred structurally into the development enterprise. In his (1972) essay; *Underdevelopment and dependence in Black Africa—origins and contemporary forms. The Journal of Modern African Studies*, *10*(04), (pp.503-524) as well as in his (1973) book *Neo-Colonialism in West Africa; & Unequal Development: An essay on the social formations of peripheral capitalism (1976);* Amin utilizes the West African context to show aspects of this resource transfer shift to be linguistic and cosmetic, not different from colonialisms intent (p.124). Amin (1997) *Capitalism in the age of globalization: The Management of Contemporary Society* and in (2006). *Beyond US hegemony: assessing the prospects for a multipolar world*; analyzes how Development was largely neo-colonialism under a different moral and rhetorical imperative to create 'undeveloped labor reserves'.

Turning to the rising Core contender the People's Republic of China where a ruling one party Communist state has embraced large elements of protectionist capitalism since 1978; Gao (2008) *The Battle for China's Past: Mao and the Cultural Revolution* Economy & Levi (2014) in *By All Means Necessary: How China's Resource Quest is Changing the World* (p. 195) and Jacques & Lane (2010) *When China Rules the World*, (p.505) there is broad speculation about the rise of the 'Civilization State'. Lin (2011) in *demystifying the Chinese economy,* attempts to strip the rise of China from Western speculations tainted with both partial understanding and xenophobia (p. 124).

Haiti Context

Peter Hallward (2007) in *Damming the Flood: Haiti, Aristide, and the Politics of Containment a*nd Dupay, A. (2007). in *The Prophet and Power* Provides a in depth analysis of what happened in Haiti after the victory of democracy and liberation theology in 1986. James, C.L.R. (1963). *The Black Jacobins. Toussaint L'Ouvature and the San Domingo Revolution* wrote a seminal depiction of the revolutionary period and the Haitian symbology for future developing nation struggles.

Robert Rotberg, (1971). *Haiti: The Politics of Squalor;* writes one of the most comprehensive generational accounts of Haiti's political ruin and outsider interference.

Dr. Paul Farmer, one of the founders of Partners in Health (2003) in *Pathologies of Power: Health, human rights, and the new war on the poor, in* (2005) T*he Uses of Haiti,* and (2011) *Haiti after the Earthquake* paints a detailed picture of politics, health and social/ political unrest in Haiti before, during and after the great quake. Paul Farmer is known as a black "neg" Haitian despite being both an American and original outsider. His anthropologist lens takes a very different look at Haitians and Haiti. Few outsiders know the country and people as well.

Bertrand Aristide, liberation theologian priest, twice democratically elected and twice coup deposed president of the Republic of Haiti wrote in (2000). *Eyes of the Heart: Seeking a Path for the Poor in the Age of Globalization.* Giving voice to the desire of people's in developing nations to find a way to development outside of neoliberalism.

Wucker, M. (2000). *Why the Cocks Fight. Dominicans, Haitians, and the Struggle for Hispaniola.* Draws a lucid history of antagonism between DR and Haiti.

Discussion

Several organizations have advanced EMS in Haiti in differing capacities. Some independently and some in alliance. Those profiled in this report are **EMPACT Northwest**, **Trek Medic International**, **Banshee Association, Lend a Hand and Foot, Global DIRT**, and **Johanniter-Unfall-Hilfe e.V.** (**JUH**; German for "St. John Accident Assistance"), commonly referred to as **Die Johanniter (St. John's)**. We believe that our effort was unique in adopting an implementing the entirety of a National Registry EMT-B course within a replicable Haitian context. It was also unique in that it produced an employable cohort that generated their own groups and sustained their own efforts via a range of economic activities in the health field and the merit of their new employable trade.

Assumptions

1. **Module based training will reduce brain drain.**

It is important to establish that all Modules are done in country and can be carried out in the most Spartan and remote of conditions. They reduce brain drain a) because all the training happens in country and b) the paramilitary, social entrepreneurial nature of EMS roots them to domestic health services. It must be understood that the rural to city train and developing nation to metropole cannot be totally stemmed in such an unequal world. However, building up a uniformed service of young people to save lives is very different pedagogy than taking people out of country to medical schools to give them routes to expatriate.

2. **Module based training will reduce dependency on donor driven development.**

Whoever contracts the module will of course have a stake in the outcome; but these modules are designed to cover dispatch, communications, financing schemes and leave a functional EMS unit in country after one years' time. The end result may run like a medical brigade, or like a two tiered volunteer ambulance service, or like a proto-Academy; but it is designed to be sustainable. These formations are not meant to be donor projects. They are designed to be accountable to their national medical services and the populations they serve.

3. **Module based training is less expensive than importing humanitarian rescue personnel.**

Even the costs of parachuting in humanitarian responders don't add up in the end. Just to move into country and maintain a Westerner costs an average of $2,000.00 in plane fair and $1,000 a month. These volunteers rarely speak the local language, they form no serious connection with the patients they operate on "rescue"; and very little capacity work is done. The most famous example is Doctors without Borders which is reliant on Western nation donors and government contracts. Dollar for dollar it will always be less expensive to sub-out foreign personnel with high living costs for investing the money to train up more locals.

4. **EMTs are more useful than CHWs as public health and safety providers.**

CHW's have a limited scope of practice and a completely un-standardized training pedagogy. The eight programs of Western NGOs are producing legions of non-independent and non-qualified personnel to do little more than public health. They are not trained for acute emergency in most instances and are not trained for disaster mitigation. Observe the following leading causes of death in the developing world.

Policy and Practice

Table 1. **Leading causes of deaths and disability-adjusted life-years (DALYs) in middle-income and low-income countries**

Causes of deaths[a]	% of total deaths	Causes of DALYs	% of total DALYs
1. Ischaemic heart disease	11.5	1. Lower respiratory infections	6.8
2. Cerebrovascular disease	8.9	2. Perinatal conditions	6.7
3. Lower respiratory infections	7.3	3. HIV/AIDS	6.6
4. HIV/AIDS	6.1	4. Meningitis	4.6
5. Perinatal conditions	5.1	5. Diarrhoeal diseases	4.6
6. Chronic obstructive pulmonary disease	4.7	6. Unipolar depressive disorders	4.0
7. Diarrhoeal diseases	4.4	7. Ischaemic heart disease	3.5
8. Tuberculosis	3.4	8. Malaria	3.0
9. Road traffic accidents	2.4	9. Cerebrovascular disease	2.9
10. Malaria	2.3	10. Road traffic accidents	2.8
11. Hypertensive heart disease	1.7	11. Tuberculosis	2.6
12. Measles	1.6	12. Congenital anomalies	2.3
13. Trachea, bronchus, lung cancers	1.6	13. Chronic obstructive pulmonary disease	2.3
14. Self-inflicted injuries	1.5	14. Measles	2.0
15. Cirrhosis of the liver	1.4	15. Cirrhosis of the liver	2.0

[a] The causes of death for which evidence for saving lives with early intervention is available are shown with dark green background.

A community health worker can distribute medications and check on after care; but most programs are not like the Iranian and PIH one; there is simply no way to integrate CHW's into higher levels of training. Most items on the above list can have their outcome highly affected by having a skilled EMT in the field. What we are advocating is to use EMT as the bridge and then built modularly to paramedic then RN in a stepwise fashion. CHW's simply are not enough.

5. **Our EMTs hold up in competency to U.S. EMTs.**

The EMTs coming out of these modules are passing US NREMT standard tests. They are practicing in busy ERs and being used in a lot more functionalities than an American EMT could hope to be employed in. Most are progressing to higher levels of training and all are passing tests that are exact replicas of questions and practical skill drills taken from U.S. EMT classrooms.

6. **Module based training can bridge from CHW to RN from the field.**

This is unproven but assumed. If EMTS are being utilized in ERs; and can be upgraded to the level of paramedic; there is no reason that RN skills and pedagogy cannot be worked into blocks to allow the best EMTs to upgrade in the integrated fashion advocated. In this was we build on a given countries need for human resources for health services without siloing.

7. **Students who pay for their training will take it more seriously.**

This assumption states that these programs can sustain themselves more independently if students pay. This is highly variable as to who takes out the initial contract. What is well understood is that this is the modal in most of the OECD world where pre-hospital care is found. Both private and government courses typically require you get their training on the outside. Having our best EMT students selected to form teaching groups for first aid has precedence in the St. Jean Ambulance model.

8. **NGOs that provide advanced life support but do not train in it are merely prolonging a problem. Module deployment affects development on a number of intersecting levels.**

Via this program functional national social service infrastructure will be established in a manner that promotes an interdependence of the existing agencies to maintain capabilities with limited outside support.

This program is to be monitored via Human Needs & Rights Based Indicators presented alongside multidimensional poverty regional data. Project operations are measured by Human Rights structural gains and advancements as well as the accepted development indicators pertaining to the vocational training being called for; in this case health.

Human Needs: this program is grounded in the basic understanding that there cannot be human rights achievement prior to meeting basic needs, but there must be full harmonization of this baseline needs objective concurrent with long term visions of human rights. Therefore all basic logical framework design, monitoring & evaluation relies on data relevant key multidimensional poverty impacts, but never deviates from explicit commitment to local rights achievement..

Human Rights: Human rights indicators measure the rights to health, education and employment via the AAAQ methodology (Acceptability, Accessibility, Availability and Quality). The main aim of this Mass Capacity Development Initiative is to train and regiment

indigenous health care providers with organizational training built into vocational modules. A Civil Service Enterprise formation based in places of extreme poverty can establish several Emergency Groups and subsequent training operations that make rights and development a fact on the ground. We believe that thoroughly organized civil service composed of emergency medical responders, educators, civil engineers and sanitation workers will improve the overall access of the population in this region to *fulfil and achieve* their human rights.

Access to Livelihoods with Dignity: By investing in communities ability to provide social service and control the means of development; you not only capacitate development you allow young women and men to pursue professional careers that are both comparatively lucrative and impactful.

Access to Healthcare: This program rapidly introduces skilled, uniformed community health workers and emergency medical technicians to a participating community. It provides functional prehospital medical care in communities with no such preexisting infrastructure and creates meaningful employment in a sector that posits natural benefit to the recipients.

Access to Education*:* The creation of a fourth sector, hybridized civil service formations will not only create mass employment as thousands are enlisted into its ranks but necessitate continuing education of public servants to reflect meaningful advancements in their sectors. One of the most prominent sectors is of course to create a dynamic and capable para-state educational system. Training teachers and other trades via the mass capacity model will improve overall country access to education. All modules are based on a system of incremental certification such that even those who do not complete our program academy will be signed off on skills that make them employable as ancillary support to the new service. Our continuing education system builds incrementally on skill sets such that will be marketable in Haiti and throughout the region.

Relations between State, NGO and Citizens: We do not believe in building up a massive NGO sector fostering dependence on international welfare or fostering a substitution effect. Raw privatization of social services also is not a viable path to human rights and self-determination in a country. Para-state Infrastructure is not in opposition to the existing agents of a state, nor is it adversarial toward NGO cooperation or private enterprise. However, as a theory of change it embraces a fourth way by which grassroots mobilization and needs of local elites converge on a uniformed, disciplined sector of civil servants who serve their people not necessarily on behalf of their states payroll system. This this can be proclaimed proudly as a national exercise in state building and patriotism, but not in the name or

ownership of an already completely discredited political institution. Our approach denies the validity of playing naïve or pretend with a virtually non-existent state systems in a given region. However, in so far as the government in question is not facilitating or directly causing human rights violations our theory of change necessitates full community control over the means of development, in this case the EMT Academy and subsequent EMS formations.

Diaspora Engagement:
Remittances are a major means for diasporic populations to return wealth to their families in country of origin. Capital inflows from the Haitian diaspora are estimated to be $1.5-1.9 billion a year (23-30%) of their 2010 GDP. Most of the existing policies in place to empower the diaspora to reinvest financial and human capital are only proving partially effective.

All project data and accounting along with Monitoring, Evaluation & Learning (MEL) data will be kept on open public record for community scrutiny, reported at GCC and CCH meetings and posted online for public view. Randomized Control Trials (RCT) are the most appropriate means of establishing the validity of the intervention.

Output Data: Attendance records are to be used to track participation. Test, exam, group project and homework scores are the documented measurement of the students medical data retention. Practical skill tests will chart skill retention. Open project reports will summarize key challenges and ongoing progress. A registry will track graduation and employment data. Time sheets will track staff hours and expense reports will track spending.

Outcomes Data: Collected 60 days from completion of each subsequent class. Will track student employment and performance.

Methodology: Utilizing an allied network to survey populations served. Documentations of validity of training, employability of skill set, and comparison of service with government assets. The Community Clearing House will be the local forum for engagement and solicitation of feedback the website will be the donor medium for monitoring progress along with scheduled weekly reports.

Approach: Transparency fosters program legitimacy.

Rationale: Responsible parties (donors & investors) will fund only what it accepts the local government won't mismanage, fairly or unfairly this reflects a diaspora bias. The EMS service

has to be compliant to national protocols and respectful of all power broking intuitions but it must demonstrate its operational capacity first and foremost accountable to the people in the community it serves.

Economic Analysis

A cost effective comparison of this measure compares the **$241,400.00** to build such a formation (where 140 are trained) and the 12K of each subsequent class (40 more) to maintain local training to the estimated cost of training one physician abroad; approx. **$354,084.00** in English medical school (government subsidized, average 12 years) or $**233,236.00** for American schools[23] (private funding, average 11-14 years), or Cuba (government subsidized, 6 years) and grants full scholarships over 10,000 additional students from developing nations each year at the Latin American Medical School (ELAM).

It is hard to compare apples to oranges; but at these costs to train MDs and the rate that they can be deployed; Community Health Workers ought to be trained as EMTs if only as an alternative stop gap maneuver until a critical mass of MDs and RNs can be accumulated in country.

It is very hard to approximate what a group might spend on the two predominantly selected modals a) the Doctors without Borders modal which deploys foreign doctors but does no capacity building and b) the PIH Model of Community Health Worker Training supporting mostly foreign nurses and doctors. Again we are comparing the EMT program to two other very dissimilar treatments.

If it costs MSF (Doctors Without Borders) $2,000.00 to fly their foreign doctor anywhere and $1,000.00 to upkeep him; then for $14,000.00 a year we get one foreign doctor who may or may not speak the language. MSF deploys around 30,000 MDs and medical workers in 70 nations for an estimated $610 million a year, 80% from private donations. That loosely means it costs MSF **$20,333.00** per single medical worker for a year. Another way of looking at that is that if one medical worker costs $20,333.00; the estimated cost of training 20 EMTs, or half a

[23] Bloomberg Business group states that $50,309 a year is the median tuition at U.S. medical schools. The Average medical school student debt is $166,750. Assuming a medical student managed to do their premedical undergrad requirements at a city or state university for around $32,000 in a 4 year BA; the price tag for 4 years of medical school not including fees and costs of living in subsequent residency programs and fellowship specializations would be roughly **$233,236.00. After that eight year period, another 3-6 years of residency and specialization is needed to produce a competent doctor.**

class; how many patents a year can an MD can competently treat. Harder to say. These are completely different resources, not every MD can get themselves out into the field. Nor can it be said that EMTs can definitively deal with all, if any medical emergencies.

Dollar for dollar it seems odd that MSF has no and desires no capacity initiatives. I think few would criticize MSF. Groups like International Medical Brigades and the Cuban Medical Brigades field large number of physicians paid for by the U.S. and Cuban states. Both have programs to bring back promising health workers and train them in RN and MD schools at cost. There are no studies about retention of RNs and MDs trained in the West returning and not defecting from their nation of origin. Suffice to say let us estimate the cost of an MD as $300 K and the cost of an RN $150 K. We are still making an uneasy comparison to say that the cost of 1 MD over 6 years or RN over 2 is measured against a certain EMT variable of providing prehospital care.

The theories of change are just so different. They are not competing, but there must be re-allocation of fund to implement these programs. Comparing an EMT against the existing Community Health worker; let us assumer we can train 140 CHWs for $500 a month. We are still comparing apples to oranges. As we are aware how many CHW, EMTS, RNs and MDs has a certain WHO ration; but because right now so few EMTs are being trained we must call into question the longer more expensive road to definitive care taking all budget items instead and ahead of having a force to bring the hospital to the field that is trained more than 8 days. Again an EMT program is 246 hours; 3 months. It's just a different level of care.

See Attached Cost break down of module.

The following organizations were & are engaged in efforts within a loose resources sharing alliance to facilitate the creation of a modern Haitian EMS system in Port Au Prince. The name of this alliance is **REZO MEDIKAL AYISYEN (RMA) or the "Haitian Medical Network".** Following an EMS Consortium held on **January 23rd, 2012** in Port Au Prince, the following non-governmental organizations, *konbits*, state agencies, social movements and associations are currently collaborating to:

a. Standardize a Haitian EMS training curriculum.
b. Support the efforts of allied organizations to train EMTs and First Responders.
c. Recruit foreign volunteers to support EMS training operations.
d. Forge collaborative mutual aid agreements with all state and non-state actors currently

working toward EMS in Haiti.

e. Coordinate a broad strategy to encourage diaspora support for a modern Haitian EMS system.
f. Build confidence with the Haitian government to recognize an official Haitian EMT certification.
g. Empower the Haitian people with the skills and training needed to respond to medical emergencies.
h. Adopt recognizable prehospital care protocols in relation to pre-hospital care in Haiti.

Index of Actively Allied Organizations

Supporting or engaging in EMS trainings

GAI; original and largest EMS formation linked to Banshee Association's earthquake volunteers; hold contracts with Medishare and DCP.

RETUM; an off shoot of GAI predominantly sustained as a first aid training group.

MASHA; an off shoot of GAI concerned with EMS temp work.

EMPACT HAITI; Haitian EMT group connected to the two Empact Northwest classes.

EMPACT NORTHWEST; a group of Seattle based paramedics and fire fighters doing disaster relief.

BANSHEE ASSOCIATION; a NYC based EMT and Paramedic fraternal organization.

HAITIAN AMERICAN CAUCUS; a Haitian Diaspora NGO.

Index of peripheral allies

Providing material support or employing Haitian EMTS

MSPP; Haitian Health Ministry
CAN; National Ambulance Service
HNP; Haitian National Police
DCP; Department of Civil Protection
JP-HRO; Jenkins Penn Haiti Relief Organization
LAHAF; Lend a Hand and Foot
AMHE; Haitian Physicians Abroad
BSVAC; Bed-Stuy Volunteer Ambulance Corps
Project Medishare; Miami based runs Bernard Mevs
Project Hope; NGO
Adventist Hospital
Physicians for Haiti/ Equal Health

Trek Medics International
MMRC; Material Management Relief Corps
GLOBAL DIRT
Haiti Air Ambulance
HERO; Haitian Emergency Rescue Organization
Equal Health (P4H)

In the aftermath of the 12 January, 2010 earthquake a wide range of emergency medical service personnel from abroad in collaboration with various factions of the Haitian diaspora began arriving in Port Au Prince with supplies, EMT training materials and foreign volunteers to outfit and organize Haitian civilians into proto-ems formations.

This cumulative effort has resulted in the full EMT training of 104 Haitians citizens, the first aid training of an estimated 551 additional civilians as community first aid responders; the training of upward of 8,000 HNP as first aiders; the creation of the CAN ambulance service and the 116 emergency number; the reaction of 4 indigenous EMS groups (Empact, GAI, RETUM and MASHA); the establishment of an air ambulance (AAA) and a private ambulance (HERO); the adaptation of an indigenous Haitian Creole taught training EMT module; however lacking government resources 116 barely covers the capital. EMT is still not a recognized, regulated medical title; most Haitian EMTs are working as nurse techs in ERs or engaged in training jobs. And a rather offensive and ego driven NGO back room haggle has prevented any meaningful alliance between the predominantly foreign, Caucasian proponents of this program, and the Haitian EMTs and CFRs themselves.

Government MSPP efforts have yield a Franco-German style EMS system introduced by Johanniter International; by all reports it is irregular and best and not staffed by highly trained medical professionals, rather often drivers with a working knowledge of first aid. As stated it does not extend past the capital and has less than 40 operational units.

MMRC, a small foreign EMS NGO had helped to facilitate the first training in Jan, 2011 before being black listed, had several members arrest on spurious charges and was forced from the country. BANSHEE & LAHAF carried out the first EMT course from Jan-July 2011 and graduated 28 EMTs that would form the GAI, RETUM and MASHA. EMPACT Northwest conducted a second EMT training in September 2011, graduating 14. The Banshee course and Empact PAPMO-1 course were in the same period and both groups BANSHEE & EMPACT NORTHWST collaborated on a third course in April 2012 which graduated 25 more EMTs. In the summer of 2014 Banshee and Empact collaborated again on a fourth class which graduated

36. EMPACT and BANSHEE along with the four Haitian EMT clusters of the first two classes began an alliance called RMA (Haitian Medical Network) to better coordinate the un-recognized efforts to promote EMS.

Following the January 26th, 2012 EMS Consortium the following groups began negotiating the details and division of labor within the RMA Alliance. A class of 26 more Haitian EMT students was graduated May 25th, 2012 bringing total number of Haitian EMTs up to 65 EMTs and 300 First Aid Responders (GAI the largest Haitian EMT grouping actively had been training in first aid skills). The efforts of the RMA participating organizations have produced a Haiti specific joint EMT-B and Community Health Worker module taught in French and Haitian Creole by GAI and EMPACT Haiti EMT graduates On May 25th, 2012 we have certified an additional 26 Haitian EMTs and to another graduating class of 35 in August of 2014; thus bringing the total number in Haiti to:

Class 0001: PAPMO1 EMS Training Program, 14 EMTs (graduated September 2011) (EMPACT & Project Medishare)

Class 0002: LAHAF EMS Training Program, 29 EMTs (graduated January 2012) (LAHAF & Banshee)

Class 0003: RMA/PAPMO1 Training Program, 26 EMTs (graduated May 2012) (EMPACT, JP-HRO, St. Jeans's, ADHE, Medishare, Banshee, GAI)

Class 0004: RMA/ HAC EMT Training Program, 35 EMTs (graduated August 2014) (Banshee, HAC, Medishare, Empact Northwest, GAI, RETUM, MASHA, Empact Haiti)

There are as of 1 January, 2015 an estimated 104 EMTs in Haiti trained in this effort. The following groups are currently participating, or tactically utilizing in the RMA framework in one form or another in support of prehospital care in Haiti:

EMPACT Northwest
EMPACT Haiti
Project Medishare
GAI *Gwoup Ayisyen Pou Ijans*
RETUM
MASHA
Banshee Association
HAC Haitian American Caucus

GLOBAL DIRT, a small foreign EMS NGO had attempted to deliver ALS care to build confidence before attempting to pitch the MSPP on their own training platform. They did several publicity driven first aid trainings with TEAM RUBICON, before disbanding in 2012. They were actively opposed to training until MSPP recognition arrived. Trek Medics via Project Hope attempted to pitch a cellular dispatch system called BEACON for rural areas and achieved, or appears to have achieved success in MSPP interest, however they are currently deploying in Dominican Republic after several of the first aiders they trained were killed in motor cycle related accidents. Trek Medic advocates a motorcycle style patient transport device and text based dispatching.

Haiti Air Ambulance and HERO are both private companies employing our students as EMTs. Project Medishare at Bernard Mevs Hospital and Adventist Hospital are the primary employers of our EMTs. Most EMT's serve a role better understood in the United States as Nurse-Tech; very few are employed on actual ambulances. Those that are, perhaps fewer than 10 work on JP-HRO or CAN ambulances.

Of the 4 proto-ems groupings; EMPACT Haiti has the highest rate of employment in NGO medical efforts but lacks any normative chain of command or independent funding base. GAI sustains its efforts with ongoing first aid training, EMT temp work and is shortly rolling out a social enterprise insurance scheme for delivery and transport of the sick and injured. HAC has made offers to run an ongoing EMT school if partners can be found. MASHA and RETUM both have their own uniforms, chains of command and also work at CAN and NGO units. RETUM is larger and better organized. MASHA is least engaged in RMA activities and organizing but has some of the strongest module LAHAF 0001 emts in it.

What is the Haitian Emergency Group (Gwoup Ayisyen pou Ijans)?

During the January 16th, 2010 deployment to Port Au Prince Haiti via the Bedstuy Ambulance Corps and the AMHE (Haitian Physicians Abroad) there emerged the need to quickly organize a vast pool of untrained Haitian volunteers and put them to work during the restoration of the General Hospital, the focal point of first wave NGO relief.

Unit C emerged in the first week of operations with the intention of organizing young Haitians organizing them to serve as first responders, translators, guides, guards and sanitation workers during the first wave's re-occupation and restoration of the General Hospital. Its objective was very simple; Haitians must be at the forefront of the relief effort because

eventually the volunteer waves would dry up and Haiti would be left to its own devices. As subsequent events have proven.

The net result of Unit C's training activities was the establishment of list of some approximately 600 Haitian volunteers that began irregularly training under a working group shortly after the volunteer waves from AMHE and Bedstuy Volunteer Ambulance Corps dried up some four months after the quake. This all Haitian islander formation, dubbed in English the 'Haitian Emergency Group' seeks to be the nucleus of volunteer EMS and Rescue service. It is this body that we can rely on for our on the ground contingent and logistical support base.

This group has received some basic training from the Canadian Red Cross and IsraAid prior to January 10th, 2011. It was further trained by Banshee-LAHAF-MMRC volunteers for the next six months. It still however lacks numerous resources, official certification and at this time state sponsorship.

One of the immediate objectives of the Banshee-LAHAF volunteer conduit (Module 0001) was to get these women and men official training, certified first responder status in Haiti and work with them to develop a long term strategy for an emergency medical system in Haiti. GAI, largely because of geography and male ego, as well as differences in vision have splintered into three groups; RETUM based in La Lue Commune and MASHA based in lower Delmas.

GAI and RETUM are primarily for profit training groups. MASHA is more like a temp agency for EMTs and EMPACT Haiti is mostly employed in the Bernard Mevs ER in a range of functionalities.

These deployments differed markedly with those of other NGOs that professed the objective of pre-hospital care. For one thing all of the American volunteers were completely unpaid. For another thing none of the Haitian EMTs were salaried by American based groups. Partners in Health focused on building a teaching hospital, the largest of its kind in Haiti and continues to train Community Health Workers called *Accampetuers*. This eight day training is focused on medication compliance and public health, not emergency pre-hospital care. Their teaching hospital opened in the summer of 2015 and is expected to train new Haitian nurses and MDs. PIH is donor reliant organization and does not sustain itself through fees.

The Die Johanniter trainings in the Franco-German modal have resulted in 8,000 Haitian National Police (many trained by our students) having first aid training. Another USAID funded government initiative is the FEMA like Department of Civil Protection and 116 Ambulance number. The result has been a 116 emergency number for the capital and about 65 ambulances donated by Brazil are irregularly staffed by RNs, drivers and first aid trained members. Most

people in the capital report that this service is not generally utilized by everyday people and response times are very long, as long as 45 minutes. The DCP has set up earthquake and storm staging caches; but several roadside disasters have not positively reflected the new services.

The Red Cross has an emergency number 115. Its drivers have no uniformity of training and neither the Die Johanniter effort or the Red Cross utilize and EMT-B curriculum. Global DIRT hoped to showcase the value of foreign EMS, but it never build the intuitional loyalty it hoped for and it disbanded in 2015 without training EMTS. It did partner with Team Rubicon to do some CME for the GAI members in 2014.

The major healthcare provider Doctors without Borders needs some mention because by all accounts most feel that MSF has no commitment to training and capacity building and the group sees its mandate only as provider. While they clearly do remarkable work in areas of great poverty and conflict; it is not cost effective nor in the theme of sustainable development to have rich country donors paying for basic medical services for the poor, but not aiding the poor in their efforts.

The largest provider of Advanced Life support in Haiti is the Cuban Medical Brigade. They have roughly 2,000 MDs and RNs in Haiti in outposts all over the country and are well known and liked by the Haitians. They have trained several thousand Haitians as MDs back in Cuba, but do not utilize EMTs in their family doctor polyclinics. ELAM; the Latin American Medical School graduates an estimated 12,000 physicians a year.

Field Report
Rezo Medikal Ayisyen (R.M.A.)
Haitian Medical Network
EMT Training Program, Class 0004
HAC Compound, Croix-des-Bouquets, Haiti
June 1st until 1st September, 2015

Beginning on 4 January 2011 a variety of Emergency Medical Services (EMS) personnel from the United States who had responded to Haiti in the immediate aftermath of the January 2010 earthquake began adapting an Emergency Medical Technician Basic (EMT-B) course to the Haitian context and shortly after began training Haitian nationals as EMT-Bs. In January 2011 Banshee, MMRC, and LAHAF began the initial pilot program in Delmas, Port Au Prince (PAP) that eventually graduated 29 EMTs. In September 2011 Empact Northwest at a base in Buju Park, PAP graduated 12 subsequent EMTs. In April 2012 a coalition of groups under the banner of "Haiti EMS Consortium" launched the "REZO MEDIKAL AYISIEN" (RMA) or "Haitian

Medical Network" which then trained 25 more EMS in PAP. Since that time 4 Haitian EMS groups have emerged **GAI, RETUM, MASHA**, and **EMPACT Haiti**; and allied groups such as JP-HRO, Adventist Hospital, St. John's, the Red Cross, Haiti Air Ambulance, Hero's for Haiti, Haitian National Ambulance Service (CAN) and Bernard Mevs/Project Medishare have begun employing our EMTS.

RMA Alliance Class 0004 has been generously hosted by the **Haitian American Caucus (HAC)** at their base 64 Double Harvest Road in Croix Des Bouquets as per the attached Terms of Reference (ToR). Our Advance Team arrived in Haiti on 4-5 June, 2014. Paramedic Walter Adler (Program Director, Instructor Coordinator) and Elena Komarova (Director of Educational Development) arrived by Capital Couch bus via the Dominican Republic and were picked up in Tabarre, PAP. They were joined the next day by WEMT-B Peter Reed (Director of Clinical Skills) and EMT-B Louis Joseph (Skills Instructor) via TLI Airport. The Haitian Instructor Coordinators were EMT Gerard Prevot and EMT Claudel Gedeon both trained in previous versions of the Haitian EMS program. The core unit of Adler, Komarova and Reed will be supported by 2 nations Prevot & Gedeon doing virtually all of the lecturing. A total of 5 volunteer foreign national/ 5 local EMT one to two week per diem instructor staff will periodically come in to reinforce practical skills. Joseph, Adman, Kim, Maclagan, and Smith.

An initial RMA meeting at Bernard Mev Hospital established between RETUM, MASHA, GAI, EMPACT Haiti, HAC, Banshee, Empact Northwest and Project Medishare established the framework for confidence building measures around the fourth Haitian EMT class.

This framework revolved around three objectives critical to the summer's efforts.

1. Train 30-40 new Haitian EMTS utilizing an "austere" modal, a fourth generation version of the Haitian EMT Program with materials taught almost entirely in Haitian Creole, with French slides and tests with a minimal cadre of foreign EMS adjunct instructors. A program that without salaries is expected to cost less than 10,000 USD.
2. Improve RMA Affiliated groups' operational capacity; identify group missions/charters/ chains of command/ visions of mission, register all members, inventory all supplies, separate greater PAP into operational Divisions; introduce Mutual Aid Agreements between groups.
3. Turn over to the allies an improved Haitian EMT Training curriculum complete with tests, power points, materials and syllabus for indigenous replication inside Haiti.

Week 1
9 June – 13 June, 2014

We began with approximately 30 pre-registered students and currently have 43 (as of 25 June). The Haitian national exam period late June to 17 July contributed to this, as well cultural inclination to allow a thing to prove itself valid before one joins it. On 10 June Paramedic Eric Adman (Program Advisor) joined our team. He helped design the two previous classes and is a senior member of Empact Northwest. A variety of factors presented early on that will continue to contribute to the hardships in delivery of course 0004.

To begin with there is an endless cloud of dust that are result of nearby national highway renovation and the erection of second school building on the HAC compound itself. The first week of school took place alongside some 300 students attending school at HAC. Subsequent weeks will take place with non-stop construction occurring less than fifty feet from our training facility classroom. In essence, we are training inside a construction site. It took several different classroom locations to balance the dust exposure. We also had to contend with heat and the constant noise of construction.

National Grid power lasts only about 4 hours a day, generally after 3PM. It is rumored the government times the activation to coincide with the World Cup games to avoid civil unrest. The radio reported large scale rioting in Champs Mars (central PAP) last week over imminent domain land seizures along the new highway route. HAC secured a backup generator, as did EMPACT Haiti that can both be run three hours at a time respectively before overheating. Much of our course requires power point presentation hampered repeatedly by power outages.

Medical Supplies are also critically short. As plainly seen in the attached inventory we are quite low on almost everything. HAC and Banshee were able to contribute to our meager diagnostic supplies while GAI and EMPACT Haiti each hauled in some of their medical cache; EMT Reed also fashioned a number of splint making materials out of found objects and wood. By the end of week one we were still quite short of every major training item. This has led to creative manufacture of materials and various attempts at local procurement via the RMA Alliance.

Classes run from 0900 to 1400 Monday to Friday, though Fridays will just be make up days for missed days during the upcoming Rainy Season; July-August. There are two paid instructor coordinators Prévot and Gedeon. (HAC and Empact Northwest are providing salaries). One of which will always be at the base delivering the modified AAOS (American Academy of Orthopedic Surgeons) power points in French or leading practical skill drills, backed up periodically by RMA affiliated allied Haitian EMTs and EMS volunteers from the US. Reed, Adler, and Komarova will be in Haiti for the duration of the course. Classes (as per schedule)

will be taught in Haitian Creole, with French Power Points, and will be supported by knowledge of the foreign EMS.

Another issue is that there are not French EMT books. In fact, we are fairly certain they do not exist. GAI is producing an amalgamated course book of St. Jeans Advanced first aid and medical student A&P text books. Students must rely on PP notes and PP emailed to them to retain medical knowledge. Only half of the 44 AAOS slides were translated or retained after last class so ongoing translation efforts will be happening.

Goals as stated in RMA meeting 6 June; a) add approximately 30 new EMTS to Haitian standing force, b) better increase operational capacity of RMA groups, c) improve and solidify the existing Haitian EMT training curriculum.

On 13 June another RMA meeting happened at Bernard Mevs to teach "Advanced Command Structures" to the allied Haitian groups. To help them compose their charters, chains of command, and decide whether their desire is to be organized as private, municipal, NGO or volunteer services.

Week 2

16 June – 20 June, 2014

The second week a full inventory was taken of supplies. Due to local allies and manufacture we have bare minimum but have submitted a detailed list to HAC for procurement especially BP cuffs, stethoscopes, and long boards. Some students coming from allied Haitian organizations have been first aid trained.

We are attempting to minimize English to Haitian-Creole translation as much as possible and empower our two Haitian instructor coordinators to ask for support when needed, not be prompted between slides. Every Sunday before the coming week, we set a lesson plan of the syllabus with a backup plan for power failure. We have a nightly meeting for the following day's educational topics, to discuss the best way to present the information to the students and the different learning styles in our class. It is important here to have a series of back up plans. Our goal is to graduate as many EMT-B's that would meet the NREMT national standard as possible. We are also assigning homework and additional clinical to make up for weather related missed days. There is an annex EMT class happening at Medishare on the weekends for several employees there and students that have to miss classes.

It is very difficult to plan for all the eventualities of Haiti. Increasingly it is very evident that EMS volunteers without French or Haitian Creole slow down the educational delivery and it would be preferable to hire two full time Haitian American paramedics as opposed to rotating in every several weeks a foreigners who cannot communicate as well.

Emphasis has been placed on short, tight phrases and avoiding needless interruption.

The first three weeks of the course emphasize practical skill training for the EMT-B with PP limited to Intro, Wellness of EMT, Medical Legal, Assessment, Vitals, Bleeding and Musculoskeletal.

EMT Joseph (a Haitian Creole speaker) departed 17 June and Paramedic Adman departed 20 June. There are not expected to be any foreign volunteers EMS until August. The program logic is that while experience of American EMS is valuable, to keep program costs in a range that will allow replication by local Haitian groups and require limited capital inputs, it is again recommended that no more than two foreign EMS be deployed at a time to support Haitian EMS. Friendly and humble are only a partial substitution, being able to speak the language is the answer. Translation slows everything down and foreign volunteers cost three or four times as much to feed and house.

Conditions here are very austere, however HAC has so far fully honored its pledge to house, feed and transport EMS volunteers for the summer. This had removed a huge cost to the effort and the logistics. A procurement order for supplies went to HAC to NYC this week. Instructors have been capable and a second RMA meeting happened at Bernard Mevs to reiterate the need for inter-group solidarity.

On 21 June Adler and Komarova went to see the base and meet the members and leadership of RETUM in La Lue, PAP. They seemed motivated organized and uniform; they had maintained a small cache of previously moved equipment and were running a first responder course in La Lue. They plan to deploy their members for Karnival in July and will continue sending support EMT instructors. RETUM considers itself a social movement for aiding Haitians through might be willing to launch a social enterprise. It is one of the so far best organized of the four independent factions not receiving external support. It has a clear chain of command and an organized program of action. It still remains to be assessed what operational capacity it has.

Also on 21 June there was a third RMA meeting at Bernard Mev facilitated by Heroic Haiti; a new agency seeking to employ many of my members and students as private ambulance company for Haiti's more affluent areas (Petionville/ Kenscoff), businesses and NGOS.

After the RMA meeting our team (Adler, Komarova, Reed) met with a leader of Haitian Emergency Rescue Organization HERO leader Stacy Lebrundi to discuss her upcoming plans to employee our RMA EMTs, offer them continuing medical education and establish EMS response and Med-Evac to those who subscribe to an insurance package her group will offer Haiti's business and NGO community beginning this fall. They seek low wage Haitian EMTs supplemented by veterans working as volunteers. Regardless of what tax filing codes say this will evidently be a service geared to the expats, NGOS workers and elites providing road side and medical evacuation.

An ongoing negotiation between the leaders of the four RMA factions will determine how many work privately for companies and NGOS, how many can join the CAN National

Ambulance as municipals, and which have a plan to provide grassroots EMS to the poor in country where compensation is unlikely and insurance non-existent.

Week 3
23 June – 27 June, 2014

Chikungunya has infected almost all of the standing personnel and staff of this facility (including 4 interns, the country director Sam Darguin, EMT Prévot, departed Program Advisor Eric Adman) and now WEMT Peter Reed. The infection presents with joint pain, fever, torso/ extremity rash and has rendered most personnel inoperable for three to four days. So far only Adler and Komarova have not succumbed to the infection. We are curious about the connection between weaponized Chikungunya and the relatively short window of infection transmission.

This week was the end of the three week intensive skills build up. So far the students have gotten training in bleeding control/ shock management. Extremity splinting. Spinal immobilization. Patient Assessment Medical and Trauma. This week we introduced airway maintenance via OPA airway adjuncts, pocket facemask ventilation/ rescue breathing, O2 administration, bag valve mask (BVM) ventilation, and adult CPR. The students are also gaining competency in accurately taking vital signs.

The students seemed very interested in the Medical Legal Ethics presentation and we feel it is very worthwhile to emphasize the EMTs role as both a clinician, a civil servant, a public health advocate and community educator.

We have three new students from the JP-HRO (Sean Penn's NGO) that is exciting since that organization has ambulance units. We have told HAC that no students will be admitted after next Monday when we begin Anatomy and Physiology. Instructor Prévot will be introducing a Friday-Saturday-Sunday refresher make up sessions at Bernard Mevs to help students catch up.

We have introduced a higher level of discipline in Week 3 which has resulted in more punctual attendance and there are approximately twenty students affiliated with the four RMA groups that have already gotten the first aid course via those groups or worked in the medical field. One of our students is a nurse in a local clinic.

The first 25 question multiple-choice test on intro to ems, wellness of EMT, and assessment was an unmitigated disaster. Every student failed. Most scores ranged 40-68. We realized that Haitians do not take multiple-choice tests. Their system relies on a fill in the blank system, which is presumably harder. This was very discouraging next to their retention it appears of practical skills, and we are have begun reevaluating the way we conduct the test. The next test will be given entirely in written for with a longer period; 45 min to test. We will also be organizing them into study groups as of next week and emailing out all power point. Our

strongest students are a cadre of Empact Haiti and RETUM members, but even they barely cleared 68. We have to strike some balance to substitute for a lack of text books.

Beginning next week it will get very A/P and Medical condition heavy. Along with the above suggestions we will be copying materials from St. Jeans to assist student with understanding of AP. EMT Reed also assisted many students in setting up email addresses.

HAC has sent our procurement requests to NYC. Along with stethoscopes, BP cuffs, and carrying devices it seems that the AAOS text book is itself a highly vital component that we cannot substitute easily.

On 27 June there was another RMA meeting at Bernard Mevs. Each group will submit a charter by next week and diagram their respective chains of command. All agree to help member registration; dividing the city into operational divisions and will be holding internal meetings at the executive level to better hone their vision of themselves as EMS organizations. It was highly stressed at this meeting, "what we will always lack in materials, money, and recognition we can make up for with discipline and increased organization". While no delegate felt any group had a precise vision of corporate identity; they all seemed interested in the notion of "social enterprise"; providing training and pre-hospital care at a fee to some to be able to provide it without charge for the poorest of Haiti. Un-officially it seems the three aims of the RMA Alliance can be summed up as the following:

1. Employment and opportunity for Haitian First Responders and EMTs.
2. Government recognition of the medical title EMT.
3. Providing prompt and professional pre-hospital care to the people of Haiti regardless of their income, race, or religion.

As we prepare to begin week four it is evident that so-called Haitian "resilience" is a combination of cooperation and improvisation; on that level we will continue to try and adapt this Anglo-American modality to the Haitian context. On another level, for the entirety of their history it seems the Haitian "resilience" is a tacit if not forced acceptance of degrading treatment, complete governmental neglect, and foreign interference. It is very hard to see things in context here, or at least in the context of normative Western standards. If we are to achieve an indigenous Haitian ambulance service that is both efficient and in the service of Haiti's poor; we must continue to reject whatever practices the NGO community has fostered or accepted here.

Everywhere is poverty and squalor. A cloud of dust and misery hangs over everyone here. There is trash littered in every street. The school system, health system and every non-privatized piece of infrastructure is a discombobulated mess. While laminated and colorful business directories proclaim "Haiti open for business" very little seems to have changed since the earthquake except most of the rubble has been carted away. Everything is dirty, crumbled, and

debilitated. The swell of foreign volunteers has thinned some back to the missionaries, MINUSTAH soldiers, and development workers. But nothing is right about Haiti.

Since the beginning of our efforts since 12 January 2010 there has been established a 116 number for a Haitian Ambulance Service (CAN), but its staff is barely trained in first aid. Sources say it is to be a Franco-German modal supported via dispatching Haitian nurses and doctors. Perhaps 10,000 Haitian National Police have been trained but no one in RMA can recount when or if they were used to provide civilians with medical aid. A source in the President's office says soon all NGOs and private citizens will be issued new identity cards and taxed. MINUSTAH reports say progress is happening everywhere. Just how little or how much has changed is about whose statistics you believe. Haiti has an air ambulance now and soon a private ambulance service called Haitian Emergency Rescue Organization (HERO HAITI) based in Petionville.

We will continue to confront challenge the illogical notion that the current conditions in Haiti are a matter of history, culture or some other particularistic determinant. The power to save lives is more powerful than the ability to take them. There are many motivations that drive this alliance. But paramount for the instructor staff this summer is increasing the total operational capacity of the alliance and weaning it to heavily off foreign dependence to replicate efforts and increase the size of the existing EMS service.

Week 4
30 June-4 July

At the beginning of the fourth week we tallied 38 students at HAC and 4 more at Bernard Mevs taking the remote version taught by Gerard Prévot and Pierre Duckens. Two have left the program; one due to being hired at Haiti Air Ambulance.

An ongoing lesson to those that will replicate this effort.

Applying Western learning styles and standards of academic measurement without gross adaptation to local tradition and reality of delivery is a *very* harmful practice. From the outset we have ascertained that the absence of French language text books (a language majority of population do not speak; and such an EMT course book does not exist in the French language) as well as reliance on power point projections with power that lasts 2-4 hours a day lends itself to massive adaptation on replicating an EMT course or course of any other nature.

But the answer is not to lower standards; it is to adapt the highest standards to local realities.

There is another issue that most Haitian exams are not multiple-choice tests. This course uses a fill in the blank test. That may be presumably easier to us in the USA, but the Haitian students find the prospect of four answers confusing and counter intuitive. We will continue to

test with 50 question multiple-choice tests, but have introduced other innovations such as fill in blank homework, subject based definition homework, group work, and enhanced clinicals to supplement the poor testing of the students on the first exam. Total failure first test (intro, wellness, medical legal).

We returned from our weekend leave to learn that the generator HAC had rented was stolen over the weekend. As Director of Clinical Skills WEMT-B Peter Reed lay in bed recuperating from the fever, rash and weakness that accompanies Chikungunya infection, a group of people walked through the compound walls that were partially leveled to install the new well and carried off the generator. Thus adding an estimated 1,200.00 expense to the HAC portfolio of un-anticipated expenditures for this effort. This theft denied us of the only reliable power source other than the national grid activation in the afternoon timed to the World Cup matches. Most Haitians favor Argentina and Brazil, which consequently are the primary contingents of MINUSTAH peacekeeping troops.

Countries contributing military personnel (7,206 in all):

Argentina (558 including a field hospital), Bolivia (208), Brazil (2,200), Canada (10), Chile (499), Croatia (3), Ecuador (67), France (2), Indonesia (167), Guatemala (118), Jordan (728), Nepal (1,075), Paraguay (31), Peru (209), the Philippines (157), Sri Lanka (959), United States (4), and Uruguay (1,135). ((CITE))

The HAC has generously supplied a variety of logistical support and the housing and food for our team. They have also provided us with a driver free of charge to and from RMA meetings. Living here continues to be still very austere. The construction effort is daily and the dust cakes anything in less than five minutes. Power goes out every night and the domestic animals (roosters, dogs, etc.) wake us early every morning. The compound has been left completely un-secured throughout the previously mentioned construction effort.

That then said it was yet another serious setback. As we began our modules on anatomy and physiology, we relied largely on illustrations of each body system drawn by Director of Educational Administration Elena Komarova. Many such large diagrams and step-by-step review of their function enabled us without power to teach the human body. Overall some dozen anatomy drawings were produced and were effective (85% of students passed exam three (A/P2, although all but two failed A/P1 they took before A/P2).

To pass this course they will need a 70% cumulative average to take the EMT Final Written Exam. We have begun re-evaluating our teaching methodology. We need to increase the amount of time that the students have to examine and copy the slides, step up note taking, utilize group work. We will also use the tests to test effectiveness of our teaching techniques by monitoring students' results. This week also the students are divided into study groups to

enhance their out-of-classroom learning. We not only plan to insure there is a computer in each group

Although our equipment and materials remain very under par for stock, we still have achieved a great deal with very little equipment. Especially thanks to the HAC cache, WEMT-B Reed improvisations, and the existing GAI and Empact Haiti caches. Despite the obvious overhead required to pay instructors as well as feed and house them along with numerous other associated costs, once this program is implemented its local delivery costs are still believed to be under 5,000 USD once "nationalized"; that is to say taught in country with full Haitian administration and delivery. That figure presumes that room/board/food/moderate logistics/ and the teaching facility itself are being provided by the partner facilitating organization (in this case HAC). That 10,000 USD (this summers presumed cost of delivery) also presumes all foreign instructor staff are volunteers and all local staff paid at comparable local wages (in Haiti 300 USD a month). (Haitian EMT's working over 40 plus hours a week at Bernard Mev Hospital make 270 USD a month).

We have repeatedly discussed and now come to believe that rotating in the support volunteers week by week as was done for the past three course generations is "feel good but not effective" except to reinforce practical skills. It is ideal to hire three native language speaking (Haitian Creole) EMS to deliver the course and ask for foreign volunteers than expect that the level of their language proficiency and ethno-centrism will evolve in one week. Of course one or two weeks is all you can expect any unpaid EMS volunteer to give, but it is not effective especially on the level of connecting to the students.

It has taken us about three weeks to learn our students names and sensibilities. Their study habits, their lateness or punctuality, their willingness to collaborate well with others. Less than 5 of the cohort can speak comprehensible English and perhaps only two can communicate with any fluency. Of the 38 EMT candidates (students) in the cohort, half commute as much as an hour and half from various communes inside P-Au-P; mostly the RMA affiliated students. The remainder, which include a local nurse, are from CDB. The P-Au-P students are generally more motivated and punctual and score higher on exams.

As stated, no student passed the initial exam on intro, medical legal and wellness of the EMT.

We have set up the class to allow those that have a cumulative average of tests, finals, homework's, group works and clinical to take the EMT Final Written Exam and Practical Exam. Those that do not will take an advanced first responder test and be certified on completion as Advanced First Responders. The goal is that as many of the class proceed into some functional medical capacity without us lowering the bar on that is an EMT in Haiti.

We suspect with 246 didactic and skills hours, over a dozen multiple choice exams modeled on NREMT tests along with three final exams, 24 clinical hours at multiple clinical

sites and a 200 question written final accompanied by seven skill stations we are raising the bar of Haitian EMS despite the adverse conditions.

There is a question of incentivization which we refer to as "jobs with dignity", "National Certification" and "Haitian Self-Determinism". Loosely this translates to the fact that many Haitians work in textile sweat shops for 250 gds (6$) a day logging 12 to 16 hour shifts. Our previous RMA students work in medical facilities at around ($270 USD) a month, but they get a real chance to progress and to help their people. MSPP recognition remains a major benchmark for us all. That they might one day be recognized by the Haitian Health Ministry is a core principle of the effort. Finally the notion of "self-determinism" has to do with Haitian patriotism and an understanding that the Republic of NGOS is not a sustainable future. They need competent Haitian institutions staffed by disciplined Haitian patriots.

The affiliated students pay half fee to be here (2,500 gds) as opposed to the non-affiliated which pay 5,000 gds (1,000 gds is around $22.00 USD/ 46 gds to 1 USD). HAC will use collected to cover the heavy expected losses the organization is willing to absorb to for paying Haitian EMT Instructor Gerard and Geraldine Prévot to teach for three months, support three foreign volunteers, pay for the lost generator, the new generator and associated petrol costs. This is the first time we have charged students to attend to cover costs which also lowers the losses HAC or any future party would absorb. There is a variety of fees you will see in the final report that inflate 10,000 USD into the typical NGO price tags. The philosophy of HAC is to create ownership have everyone buy in for nothing is free without dependency. We fully agree. Haitians believe something given to them for free has no value. Like the rice dumped on them every year by USAID which devastated the local rice market. Or a variety of other bulk consumer items fostered on them via "charitable giving". One "use of Haiti" appears to be a consumer dumping ground for the US; rice, pasta and textiles.

Examining the costs of the previous three efforts we believe this will surely be the "austere operation". Running the books on the 2011 Banshee-LAHAF effort the first RMA EMS Class 0001; for 32 foreign volunteers working over 6 months, all associated costs of operations and logistic had to be raised, airfare itself would be (approx. 32,000 USD), considering the 10,000 USD estimated value of donated equipment carried in and other related expenses of those 6 months the bill would be nearly 80,000.00 USD to train 29 Haitian EMTs.

Considering EMPACT Northwest led classes in Sept 2011 and April 2012 utilized less volunteers (though not that many less) for shorter periods (about two months a class) unable to examine their books we put cost per class at less, but not much less and those two classes created an additional 11 + 25 Haitian EMTS.

The sustainability of this effort in Haiti or elsewhere is to determine how inexpensively the pilot program can be implemented, how quickly a second generation can be taught in local language instruction with local language materials. And by stage three of four how it can be

replicated in country without paying for foreign support. And such is the rhetoric of all development enterprises but there is also a different kind of step four.

It is a political act that can control a force of uniformed rescuers able to teach, heal and save lives. So, stage four has a lot to do with what the RMA (Haitian Medical Network) or a similar grouping decides to be. A social enterprise like the one in Mumbai, India seeded by global fund Acumen with now over 300 ambulances running 25 hours a day? It is going to become a private company delivering evidently and reportedly half free care and half charge. Or will it be a volunteer agency like BRAVO or HATZALAH in the United States supported by the community. Or will it transform into a Haitian NGO or CBO (non-governmental organization/ community based organization). Will it become its own Haitian private ambulance company or be more like a union or trade association? The development workers reluctance to ask political questions or see development work as inherently political is firstly naïve and secondly dangerous and thirdly pathetic. It is indeed political who will control EMS in Haiti. And that is why everyone is meeting to decide who will.

Hero Haiti the new private ambulance company based in Petionville would like to pay our EMTs and rely on foreign support from military vets to deliver for profit ambulance services. They are organized and seem highly funded with no less than three medical evacuation planes ready in Tabarre. They are calculated and connected and will very likely in September be the most competent private service in the country. We hold their country director Ms. Librundi in high regard and see this as a vital niche for countrywide EMS. Our concern remains that like the new Haiti Air Ambulance (HAA) few regular Haitians will get to utilize if afford it. Now there can be no doubt that both medevac and private companies are needed and we see that both employ and plan to employ our former students. HERO has actively held a meeting for RMA EMTs to seek employment and HAA currently employs one of our head instructors EMT Claudel Gedeon. The issue is scale. It is not needed to get an air ambulance to peasants dying of Malaria or a medevac for peasants dying of cholera. These resources are not going to be affordable for average Haitians. 82% Haitians are peasants living on or below 2 USD a day. They will not be calling HAA or HERO.

The CAN Ambulance service under the jurisdiction of the MSPP (Haitian Health Ministry) is growing. It is mostly staffed with driver-secourists (first aiders) and "normally" an RN or MD. There are so few Haitian RN and MDs that this seems unlikely. It is also allegedly very political who even get an ambulance. You can call 116 but ambulances (there are now estimated to be around 60 functional ones; down from the 106 turned over two years ago from Brazil and Cuba) will always be redirected to relatives of government officials or other powerful people. They will get utilized inappropriately and inefficiently. A deputy ministers son could get an MD for a nose bleed but a traffic accident could wait hours still. There is active effort to integrate Haitian National Police (10,000 plus of which are first aid trained) the *Pompiers* (fire

fighters) and CAN into an effective NIMS based network. As of now calling 116 is a purely PAP upper class reality. 118 might get you a Red Cross Ambulance. Who is on these ambulances and what they know how to do is subject of much discussion. And it is an very political question guarded by the Martelly Government how prepared Haiti really is for any emergency. We continue to hope the MSPP will recognize the EMT Credential in Haiti, but are not holding our breath.

NGOs seem to still not make EMS training any serious operational priority. In fact the head of medical education at Project Medishare has worked actively all summer to undermine this effort and call into question the credentials of both Haitian EMTs and instructors. All the time he is paid employee of an NGO running "in partnership" the Haitian Hospital Bernard Mevs living quite well in Haiti working out business deals with HAA, HERO, and new a NGO that will send Haitian children to Korea to get cardiac surgery.

Residents from university of Miami staff Bernard Mevs which is better than nothing of course and this remains one of the best local hospitals. Project Medishare has always been a partner in EMS training and employees many RMA EMTS as nurse techs. Mr. Smith however continues to slander this program and its instructor staff both Haitian and American.

Also "political" is the Cuban medical brigade leadership that we are meeting with on Friday. We hope the Cubans will allow our students access to their numerous hospitals as clinical sites, particularly the one five minutes from our base at HAC. Free medical care brought to Haiti via a partnership with Cuba and Venezuela has 700 MDs in country, 17 medical outposts, clinic and hospitals all over Haiti and has trained 1,100 Haitians in Cuba as MDs. Political because this is their foreign policy and we will have to make reports in PAP to be send to Havana before this can be authorized. Dr. Camillo and Dr. Walfredo the Cuban MDs are very supportive and have referred us to the Embassy to get a meeting set up with the head of the Brigade.

Finally, as we continue to interact with Haiti's "Middle Eastern community" we glean more information about who is a friend/ enemy of progress. The Middle Eastern community which is Syrian, Lebanese and Palestinian mostly have been here for over four generations. While the community may number only a little over 10,000 they seem to be the primary arbiters and investors in legitimate business, local tourism, restaurants, super markets, gas stations and behind the scenes have seen and do a great deal without any direct political participation. They are internationally educated and cosmopolitan. As well as gracious and generous hosts. Our new friends have helped us to see other aspects of Haiti you would never see the trenches. That there is certainly a lot of wealth and high living to protect at the top of the hill. They told us that they were targeted heavily for kidnapping in the period post 1986 when Jean Claude Duvalier fled into exile. They have a stake here as strong as any other faction and would like an ambulance for an emergency as much as wealthy mullato, wealthy noire, NGO employee or peasant. When addressing the issue of politics we were told they stay out because it is too visible and dangerous.

There are two classes here they told us, "those who can easily leave and those that cannot" and everything is else is just a question of race, politics, money and power.

There is a conference being held next week hosted by the Southern Command of the US military with a price tag of 30,000 USD for four days of meetings between HNP, MSPP, CAN, Department of Civil Protection, Red Cross, HERO and other medical serious players. WEMT-B Director of Clinical Skills will attend along with all of the RMA leaders.

So quite a lot of people are interested in EMTs. Just who gets the credit and who makes the money is beyond our pay grade but certainly has a lot to do with what kind of EMS system Haitian will have.

Without power, using largely hand drawn diagrams made by Ms. Komarova we taught A/P all week and began introduction of CPR and Ventilation skills. All of our students received assistance in setting up email addresses, have been divided into 6 squads "study groups", and have elected 2 delegates and 2 deputy delegates to represent them.

On 4 July AEMT-P Adler, Komarova and EMT-I Gerard Prévot met with the deputy consul of the Cuban Embassy in *Peguy-ville* to make a report and gain authorization to meet with the heads of the Cuban Medical Brigade next Friday. The deputy consul conducted the meeting in French with EMT Prévot and granted us authorization to proceed. The Cubans seem excited about the prospects of mass training Haitians as EMS to supplement existing local infrastructure.

We visited the new HERO base on Pan-American Avenue/ John Brown and saw a well-organized facility well set up for dispatch, accommodating foreign volunteers and staging for a single red cross ambulance. It appears HERO had strong patrons but no medical personnel or clear vision for how to attract unpaid/ low paid hires other than our students. They hope to begin offering pay-for-service EMS and road side assistance beginning in September augmented with veterans serving as volunteers via a partnership with Team Rubicon, but this may be an optimistic assessment.

Week 5
7 July -11 July

When we returned from weekend leave in PAP Sunday we were told HAC had rented a new generator. The compound is visibly being renovated top to bottom. Tiled floors on the ground level, a new well, a new inverter to buy us at least four more hours after it charges on the grid. The back yard we cleared of trash and burned is not a staging point for cement mixing. The second new school building we are told will be operational in three more weeks.

Attendance is up. The students have been told three lateness is one absence, and three absences is grounds for termination. That then said many (half) travel over 2 hours from PAP on tap-tap omnibuses that are both dangerous and irregular. Normally there had only been 25/ 43

enrolled students there at any given time, but National Exam month is finally over and we began on the 7th with 33. After the A/P test there will be a grading and attendance based purge of the roster. After that they will proceed needing a 70% cumulative test average to take the final 200 question exam and final practical in late August. 3 late nesses excluding storm or family emergency equal one absence, three absences is grounds for review and termination. They can utilize homework and extra clinical to boost their average.

We continue to state, "we are not here to teach you to take American tests, but you must utilize these tests to improve your medical knowledge and document your progress for outsider audit." With intermittent power thanks to the new generator we accomplished more A/P study and had reviewed all body systems before Thursdays third EXAM A/P 2.

On the morning of 10 July AEMT-P Adler and EMT-I Geraldine Prévot met with the leadership of the Cuban Medical Brigades to present on the methodology and design of the RMA EMT program. The Cuban Brigade leadership in Haiti seemed highly impressed with the effort and said they would be making a report to Havana for authorization, setting up a second meeting in early August and looked forward to assisting RMA in its negotiations with the MSPP.

On the evening of 10 July (Thursday) there was a sit down of the RMA leadership excluding (because of work scheduling) Empact Haiti. All of GAI, RETUM, and MASHA command leadership were present at the Plaza Hotel on Champs Mars. It seemed like we had stepped into a time warp where the Cold War had never ended and that was because we had. The Cubans seemed very interested in the fact that ambulance workers had created parallel structures as medical brigades without any support from our government and carried out the classes in their conception of solidarity.

After reviewing the intelligence gathered by the four groups present on EMS player in Haiti and speaking about immediate needs/ v. long term ambitions; the RMA groups, pending negotiations with EMPACT Haiti have agreed to create an Executive Command with one leader per group (4) and staff seven operation sections with mixed membership: LIASON Section, COMMUNICAIONS Section, SAFETY Section, OPERTATIONS Section, LOGISTICS Section, PLANNING Section, and FINANCE Section in accordance with the National Incident Management System (NIMS/ NICS). They have agreed to meet with their members and respective leaderships to draft an organizational charter of the RMA. And fully deploy between 50 and 100 Haitian EMTs and Secouristes at the upcoming Karnival on the weekend of 26 July.

The meeting lasted nearly 3 hours in English and Haitian Creole. It was stressed that for a group of 65 EMTs and 500 responders with almost no resources to sit at the table with the MSPP, Cubans, MINUSTAH, NGOS, or other players they has better be, or appear unified for bargaining to be lucrative.

EMT Reed attending a disaster relief meeting earlier in the month that had representatives from the DPC (Department of Civil Protection, Haitian National Police HNP,

Haitian National Fire, Haitian Coat Guard, six members of the Louisiana National Guard, three members of HERO (Haitian Emergency Response Operations), CAN, the MSPP and several leaders of the Haitian EMS groups in RMA. Over three days they discussed (for the first time in this face to face setting) realistic strategies for a verity of possible disasters and situations. The first day was an introduction period where all the different groups explained their particular role and gave examples from previous disasters. Each group voiced problems and frustrations that they had faced and how they overcame them. Group scenarios were used to test the different group's strategies as a whole. By the end, all of the groups had open and clear lines of communication for the upcoming hurricane season.

$30,000 USD and three days of meeting later there was still no clear or codified plan for mass emergencies in Haiti. RMA leaders did use the meeting to present a response plan during the upcoming Karnival and be recognized as four distinct Haitian EMT organizations, independent of NGO backers.

Week 6
14 July – 18 July

On 14 July our students took, and all but 6 passed the A & P exam (50 questions multiple choice) in flying colors. We like these progress measurable in the West, but the goals remains to impart and get it to stick real knowledge. The 6 that failed had missed a great deal of previous class due to National Exams and will retake the A/P in two more weeks.

Gerard Prévot and other RMA leaders continue to meet with CAN and DPC to allow they network to work in a support role during Karnival and it look as though this will proceed. Clinical rotations have begun at Bernard Mevs hospital (the students need 24 clinical hours.) By all reports they are doing very well. Attendance is up to a normal 28-32 students a day. Most of the Medical Section will be completed by next week. The students seem to excel at Medical Evaluation. Overall there is marked improvement in all regards. The study groups are meeting outside of the class twice a week A, B, C, D, E. Except for B which is some of the weakest students and will be re-organized. There are also 3 additional students taking a "remote" version of the course at Bernard Mevs, their reintegration of testing remains unresolved.

In conclusion; the Cuban Medical Brigade and the GAI performance at the upcoming Karnival will likely again force the issue before the MSSP.

Week 7-10
20 July-20 August

There is not much that occurred to radically alter the dynamics of our students success. They each performed successively better on tests, except for the two that never seemed to pass a test no matter what we arranged. Discussions have begun with local HAC leadership for HAC to join the RMA as a permanent EMS Academy. If this occurs, it will allow a base and conduit for an all Haitian EMS effort to proceed.

Week 11-12

20 August to 1 September

The only thing to support was our success. After an entire day of practical testing aided by MASHA and RETUM we tested out 36 students; all of which passed a 200 question multiple choice exam and graduated 1 September as EMTs in a ceremony HAC produced. Without a doubt we have proven that the largest most indigenous course could be carried out for under $12,000 USD (with no one but the Haitian EMT instructors being paid) and that limiting adjunct parachute staff for full time lean group of teachers was ideal.

Recommendations

Mass Capacity Modules (MCM) are the latest operational innovation in the field of sustainable development. They are based primarily on a participatory methodology that allow the practitioner the ability to form their projects on the ground based fully on indigenous knowledge (IK), indigenous need (IN) and most importantly direct empowerment.

Modules themselves are vocational training programs that target key indicators of multidimensional poverty namely health, education and living standards while measuring success utilizing an innovative system of IK inputs and human rights indicators. Formed around achievement on the ground of measurable human rights entitlements. MCM evolve in four generations; four cycles of three-month intensive training that impart employable skills while organizing the cadre into local functional units specialized in the area of need.

Smallest scale operations utilize a rotating staff of five instructors to forty students gradually scaling back over the course of one year all foreign technical support with each cycle until the fourth version is completely replicable by local CBOs stakeholder Alliance. As each cycle runs it incorporates more IK/ IN, more nuanced learning adaptations to the community while setting up the operational framework to utilize the new capacity; namely emergency medical workers, teachers, civil engineers, hydrologists, agronomists,

construction/electric/energy engineers, fire/rescue/peacekeepers, mediators, paralegals, and numerous other needed paraprofessionals.

Combining the most efficient pedagogy of vocational training honed under austere conditions with low cost technology to deliver the most lasting results in capacity building the MCM system not only imparts training it adapts its relevance to the particular community it serves. CBO stakeholders as well as the public, private & NGO sector can send student candidates to enhance their development capacity. Where no such stakeholder alliance exists in the given sector functionality (Health, Education and Living Standard direct improvement) this system will subsequently organize new formations out of the graduating students called Civil Service Enterprises (CSE).

Individuals now trained with new skills to sustainable develop and empower their community in public, private, NGO or CBO partnerships for capability now offer real impacts without the costs of ongoing technocracy. Accountable foremost to the communities they serve while still able to advance their training in livelihoods with dignity of their own choosing.

What we aim to demonstrate via a series of operational deployments in the field is that with austere resource commitments, small multinational crews, and the engagement of local groups we can begin to establish training that will allow the communities to quickly control their own means of development via seeding functional Civil Service Enterprises.

Modules are presented to the community for popular selection of 1-5 modules per 1 year project cycle, broken into class cadres of 3-6 month vocational training segments. The Module vocational training skeletons are enhanced with indigenous knowledge and need to be fully localized to local context. Operational, logistics, communications and financial elements are built in to ensure the emergence of a functional Civil Service Enterprise after one year or training operations.

Training Ratio is 40:5; forty students to 5 instructors; one in charge of skills (Practical Skills Coordinator), one in charge of didactic instruction (Instructor Coordinator); one Educational Administrator (module pedagogy improvement) and two back up skills instructors. All modules run for 3 months, involve regular testing and attendance metrics and result in certification for the skill/ trade they are learning upon successful completion of the program. Students are issued certification papers which allow them to practice the skill/ trade for a period of three years. Provided they complete continuing education and pass re-certification, depending on skill students are then licensed to practice the trade.

Module skeletons are built by fusion of existing national certification standard trainings with Solidarity Systems Civil Service Enterprise curriculum development and delivery modals.

Modules must be adopted throughout the developing world to create fully integrated health services and lay foundations for more sophisticated bridge programs from Community Health Worker to nurse. It must be proven on the ground that this modal operationally and fiscally is more competitive than the zeitgeist to train irregular community health workers, then send the best ones off to nursing and medical school.

A fully integrated health service places emphasis on allowing base level practitioners at the earliest possible age to enter a medical hierarchy, and upgrade their credentialing and training levels though a harmonized system of continuing medical education. Most nations (with the possible exceptions of Cuba and Israel) silo health workers into ancillary paraprofessional roles (EMT, Paramedic, and nursing technicians), nursing hierarchies or physician hierarchies that are very linked to class and opportunity. Community Health Workers have not been properly integrated into this medical hierarchy or silo system except in Iran and via Partners in Health's selection for medical upgrade to RN or MD. In a fully integrated health service young men and women being their training as an 5-8 day community health workers, and use the emergency prehospital care professions EMT (3 months) & Paramedic (2 year) as the practical upgrade bridge to RN (4 years); then subsequently based on testing, clinical competency and academic ability promote to PA (5 years) then MD (7 years). This system allows functional clinical learning while providing needed patient care. The other critical pedagogical deviation from the North-Western cost and modal is that students a) remain employed after their three month EMT bridge and b) promote up a single educational silo based on competency and c) their primary employer is the Civil Service Enterprise that sponsors them.

There are three major modalities for training providers of pre-Hospital Care; the Anglo-American model, the Franco-German model and the fully-integrated model. The Anglo-American model relies on EMT-Bs and Paramedics to extend the physician out into the field and extract the sick and injured back to a hospital. EMT-Bs are trained in 246 hours, or around 3 months and paramedics 1-2 years. They function on advanced directives called protocols where MDs sign off on what lifesaving interventions they can do in the field or via telemetry.

The Franco-German system placed MDs and RNs on ambulances in effect extending the ER into the field. The fully integrated system used only in Israel and Cuba places all levels of provider onto ambulances appropriate to call type but draws the best providers into higher levels of training instead of siloing as the other two types do.

Our solution is to widely expand the scope of practice of the community health worker through a series of paraprofessional training modules that generate operational health services, community-based organizations (CBOs) called *Civil Service Enterprises* (CSE). This method can lead to a rapid expansion of uniformed health service providers who meet performance standards regulated by regional health policy. It allows a pathways for professional continuing medical education from community health worker up the medical training hierarchy while improving the medical skills, mobility and agency of the providers trained from the local community where the need exists.

We recommend that each module is geared to establish a Civil Service Enterprise; similar to a Social Enterprise, but explicitly serving in public-private partnership to re-establish a a critical social service that has fallen into non-existence or neglect due to fiscal austerity of state budgets. Civil Service Enterprises are derivative of practices extrapolated by ABCDIII actors; *Acumen*, *BRAC*, Cuba, Iran, Israel and the *Indian Skill Development Corporation*. It is a policy for reconstruction of health services modeled austerely for direct implementation.

NGOs Acumen and BRAC international have developed valid financing schemes to fund such enterprises in a full range of development sectors. These social enterprises link back to the NGO's that seeded them through something called backwards and forwards linkages; funding pipelines that link a valid business to a social mission. They also are designed to help support a valid functionality of the NGO's local work. Acumen accomplishes this through venture capital philanthropy and BRAC through microcredit loans. Acumen has built a viable ambulance service in Mumbai, India though its health portfolio. BRAC proliferates community health workers, but also trains more advanced staff in its paraprofessional programs and university. BRAC utilizes backward and forward linkages to link up all sectors in its mission to end extreme poverty. Acumen utilizes something called patient capital; longer term loans on social causes, 500 K to 3 million in loans and equity. Acumen has seeded over 88 social enterprises. BRAC is a veritable empire of over 90,000 plus employees in 14 countries combining development services, social enterprise, handicrafts and a major school system.

The work of the Cuban Health Ministry has shown the high level impacts of equal access to health services, and how developing nations use them to achieve domestic health outcomes and sot power abroad. They currently export medical workers (estimated at 6% of GDP) with approximately 55,000 Cuban-trained medical professionals serving abroad in 66 nations[24] while maintaining health standards surpassing most of the developed world (Feinsilver, 2008). Over

[24] 30,000 in Venezuela, 7,400 in Brazil and 900 in Haiti are the three largest contingents. 23,000 physicians from low-income communities in 83 countries (including the U.S.) have graduated from ELAM, and nearly 10,000 are currently enrolled.

2,000 Cuban MDs and RNs currently serve in Haiti. The Cuban modal has been valuable to study the high level of development the Cuban people have achieved with such uniform investment in training and educating their people. While Cuba is not big on community health worker or EMT programs; their Medical Brigades have demonstrated the good will Cuba has earned by establishing health services.

The Iranian Behvarzan integrated Community Health Worker system has been credited with radically improving health outcomes (Tavassoli, 2008). The Iranian modal of fully integrated systems is similar to the Soviet Fletcher system[25] of training the provider almost totally in the field. Partners in Health has proven the impact of health workers augmenting NGO medical delivery systems. Their community health workers augment their MDs in a wide range of settings. The PIH methodology is to build facilities then get them staffed by turning them into teaching hospitals for the best of the CHWs. Both PIH and the Iranians have shown the value of training lay people in austere settings then gradually up-skilling them as they work. This is markedly similar to the Sino-Soviet health service; where cadres of barefoot doctors and medical students working and training as they provided healthcare. I believe they only did this barefoot in China.

The Indian Skill Development Corporation has made massive up-skilling of its citizens a national priority. It has set up in 21 lines of industry a major drive to up-skill and train its labor force. Such is the world's largest single investment in mass capacity since China and the Soviet Union. No nation in modern history has made vocational training for the masses such a priority, but its 21 trades are very different from the 12 Keystone trades recommended here.

The State of Israel has modeled one of the most integrated health systems on earth. Its medical system can merge at all levels with its military and there is one of the highest levels of pre-hospital care on earth. Another Israeli innovation we have examined is the idea of capacity as development; Mashav, its development agency makes training of foreign personnel a major priority.

The idea of a module based training regimen as advocated by this paper has been influenced by all of the above actors and what we perceive is their placement of human capacity at the forefront of development. Despite these all these exceptional efforts, there is still a critical shortage of professionally-trained, front line health workers (MDs, RNs, midwives & CHW) and a pressing need for grassroots medical training in austere regions and conflict rife states.

[25] The Soviet Fletcher System

Our Research & Development team at the Heller School for Social Policy & Management at Brandies University has recently developed and field-tested a hybrid solution to pre-hospital care delivery that falls between the current trinity of private sector, non-governmental organizational and government providers[26]. Our training methodology can quickly, efficiently and cost effectively, augment the medical services of developing nations as point of entry to train communities in a range of sectors. Our solution is to widely expand the scope of practice of the community health worker through a series of professional training modules that generate operational health service, community-based organizations (CBOs) called *Civil Service Enterprises* (CSE). This method can lead to a rapid expansion of uniformed health service providers who meet performance standards regulated by regional health policy. It allows for pathways for professional continuing medical education from community health worker to registered nurse, while improving the medical skills mobility and agency of the providers trained from the local community where the need exists.

Amalgamating aspects of Community Paramedicine, public health, and emergency basic life support, pre-hospital care, we offer a bold new training paradigm. The Mass Capacity Module System (MCM) is an innovation in development that couples vocational training operations in austere conditions in the medical sector with hybridized social entrepreneurship. Where there are no local resources to pay these health workers our methods propose a range of finance schemes based upon valid Southern precedent.

The global proliferation of community health workers has been credited throughout the development enterprise as an integral aspect of poverty alleviation and disease prevention. But a bridge must exist between the 5-8 day Community Health Worker modal of groups like Partners in Health and the expensive and foreign dependent expatriate training modals such as those used by Clinton Health Access Initiative (CHAI).

EMT training modules have been developed in English, French and Haitian Creole with all associated materials. We maintain a roster of multi-national/multi-lingual EMT / Paramedic instructors and an incorporated status for sub-contracting the platform. We have medical control and operational protocols codified. We can engage a group of 40 civilians or current community health workers and train them over 246 hours (3 months) to the operational level of Emergency Medical Technician with a core staff of 5, only two of which are non-indigenous. In a one-year project cycle divided into four class 'generations' at minimum staffing the expected output is 160

[26] Emergency Group Solutions, an LLC formed by Heller School Graduates.

EMT Medical Workers, a local Civil Service Enterprise for delivery and a localized replicable EMT module tailored to local context.

Management should always be authorized by a National Health Ministry, facilitated by a regional NGO with full CBO stakeholder involvement to seed a pre-hospital care provision social enterprise called a Civil Service Enterprise (CSE). Organizational adaptation of methodology exponentially cuts delivery costs. Beyond livelihoods with dignity is ingenious control of development. We are in the process of adapting this training technology into three additional critical health development bridge sectors (CHW-EMT, EMT-MEDIC, and MEDIC-RN) in an effort to proliferate the methodology. Currently we seek a leading Southern Development organization such as BRAC or the Cuban Medical Brigades to upscale and fully internationalize the work. Beginning with healthcare and evolving into education, agronomy and infrastructure development we aspire to not only teach women and men of the developing world 'to fish'; we yearn for them to combine self-reliance and entrepreneurial spirit to achieve the kinds of needs and rights codified & promised in the halls of the United Nations, but left far too often to whims of donors to carry out in the field.

Specifically and immediately, in Haiti, DR, Jamaica, subsequently in Colombia, Sierra Leone, Bangladesh, Burma and Greater Kurdistan. The logic of these locales will be explained in depth. The goal of each emergency group is to establish a useful beach head to advance further trainings and correlated social enterprises. EMS is not always the first logical segway, but it is a needed one. The expansion of efforts in Haiti takes is the magnitude of the Haitian victory in the consciousness of the developing world. Ignored is the historical moment of a multi-racial triumph over slavery and racial apartheid. It is for that reason that the Haitian Emergency Group has taken on extra significance and attention especially due to so many stalemates precedence because Haiti holds both practical and symbolic significance. Ignored in white Western consciousness and mishaps in Haiti's supposed "development".

There are two ways to proliferate this training modal. One is the grassroots and the other is via contracts. The grassroots is more humble and in touch with the factions that most deserve it. You sacrifice resources for autonomy and integrity; but there must be balance because it is difficult to sustain the training without operational investments that are hard to come by without contracts.

Contracts however will mostly come from sectors with interests and those interests are the entrenched interests of development critiqued in the macro level analysis. But you cannot surrender resources for principles as NGOs of scale know so well. The primary mission is proliferation of the module technology and through proliferation add an increased array of Key Stone trades to the open source tool kits that can then find their way to the grassroots. But

proliferators must eat and so the following are suggested locations to strengthen the EMT Module and prove that year long, four cycle deployments yield the promised fruit of 140 medical rescue workers and a localized module that can be replicated without external supports. This is a very tempting offer for the price put on it, but finding the balance between contract and grassroots is a matter of strategic planning.

Staying the course in Haiti is essential. First, successes and alliances make work easier than launching the module in a completely new context. A Haitian NGO Colors of Hope hopes to secure our module for a year of training in the IDP camps called Canaan; a tent city in the Haitian desert of earthquake refugees without hope or employment. It would be an excellent controlled location (one of over 100,000 people) to see if the one year, four cycle program yields the kind of needed result we promise and believe it will. Haiti is the best place to compare results of the four pilot courses to what we will set up with MEL QED to track the fifth round of the program. Canaan is also cut off from the bustling city centers of Croix des Bouquets and Port Au Prince which will make the rationale for NGO and government support high and attract attention for future proliferation. Colors of Hope is led by a serious ally of the EMT Program and doing the first contract with such institutional support is vital.

As resources make themselves available expansion into Kingston, Jamaica is an important location not because of overwhelming need but also proximity to Haiti. DR is a logical step because of the historic rift but there only is fairly functional Red Cross based services and ambulances in DR making the need much less. Jamaica and DR will come through contracts that seek to generate more profitable and better trained medical response services than those the Red Cross provides. In essence Jamaica doesn't even have Red Cross Ambulances they have very little at all. An irregular patch work of throwing people into non-ambulance transports. If expanding Haiti is for the most part a grassroots in its perspective the DR and Jamaica module contracts will be aimed at private sector investments to compete with inadequate charitable services. These will be modelled on social enterprises with multiple shareholders that aim to create ambulance services in the country that will function within the guidelines of private-public partnerships. DR as a Spanish speaking country and Jamaica as an English speaking one add the value of placing the module in a regional framework where supply lines of trainers and equipment would not be hard to maintain.

The third stage of proliferation is to get direct government contracts in Sierra Leone where the health service is almost non-existent and Iraqi Kurdistan which is both under siege and is institution building in all areas as it cautiously prepares for statehood. Let me speak to these two cases separately.

In Sierra Leone the government has come under pressure post the Ebola Epidemic to square away, i.e. build nearly from scratch a health service. NGO imperatives on nurses and doctors are costly and time consuming. A fully integrated health service is appropriate for nation's building from scratch. There is political will for such a service and a likelihood of winning a contract.

In Iraqi Kurdistan a range of forces have aligned to make the push for independence more likely. Syria had collapsed, Iraq had been de-facto partitioned. The Kurdish political factions can clearly benefit from front line EMS personnel and Kurdistan is exciting from the macro-level because should an EMT Program be successful it would be a fantastic context to deploy other modules in the effort to build the parallel Kurdish state.

Conclusion

My original work has often been a hardline critique of a development enterprise that so often appears to do business, cloak opportunism and mask cultural disregard in the lens of the humanitarian imperative. Development has so many forms and it was not my place here to critique and contrast. Suffice to say I believe in Mass Capacity; I believe in investing in the people of the poorest nations and earth and allowing them uniformed, civil service enterprises that restore national pride and go after the root causes of poverty. I believe that an EMT program is a good way to expand the reach and capacity of any developing nation health service. I believe that dollar for dollar, and especially in regards to the kind of young people attracted to the emergency medical services; we are not talking about vocational training.

We are talking about applying a paramilitary *espirit du corps* to health and human services. We are talking about a multi-sector initiative that restores with each class more human resources for health services back to the nation that invests in them. By deploying the module in your country you are making an investment in the capacity needed to save lives and respond to disasters. You are investing in self-determination and control of the means of development.

The solution to this series of overlapping, multi-dimensional problems is a massive investment in fourth sector[27] human capacity. Proliferation of the trades and professions most needed to alleviate this highly systemic injustice, while placing their service distribution and control at most local community level of administration. To thus wean humans off unnecessary dependency; political subservience to self-dealing national elites often directly linked to the

[27] The fourth sector is a broad amalgam of organized civil society actors such as community groups, social movements, farming collectives, clubs & associations, trade unions, religious institutions and grassroots actors funded directly by the local community they operate in. An actor is not a fourth sector actor if they are a) 20% or more deriving funds outside their service area from national government, foreign government via NGO capital intermediary, foreign direct investment and/ or multilateral grant making.

economic domination by foreigners; building on the ancient proverb, the 'teaching of people to fish' and drawing on examples throughout the international development arena that grant wider access to a larger pond.

Healthcare and Human Rights are interrelated objectives. Healthcare is a human right, but human rates are worth the paper and walls they are printed on when men and women die early because of injury, starvation and printable disease. Sustainable development, human rights advocacy and peacebuilding are deeply integral fields. To address war, poverty and disastrous climate change we must understand the interconnectivity. Rather than embrace technocratic generalists we must focus on efforts that provide mass capacity; that is to say the broad based investment of multi-sector training into a developing nation's population .We are currently seeing global health, security and overall human rights deterioration via numerous failed Northern economic aid incentives, escalating internal conflicts, as well as the effects climate change. Underlying is the reality that 4 billion human beings living on less than 4 dollars per family per day. My field work and research will examine solutions to this vast human misery that circumvent corrupt governments, big power politics and corrupted states. Mass Capacity Building as defined by this project will be about putting skills, training and organizational capability South-South into the hands of the people with a special emphasis on health. The concept of the Parallel State is about identification of the functional components that capacity efforts must be focused into to fulfil governmental prerogatives while avoiding confrontation.

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Annex 1: Modules & Keystone Trades

Modules are training systems that rapidly impart hard skills, continuing education, management and vocational training through a systems based approach which focus on *12 Keystone Trades*, but are not limited to them. *The 12 Keystone trades are;*

Health
Education
Construction Trades

Civil Affairs
Livelihoods & Asset Management
Safety & Emergency Response
Sustainable Energy Resources
Recycling & Sanitation
Communications, Media & IT
Transport Logistics
Civil Engineering
Environmental Conservation & Management

Mass Capacity Modules

The following twelve keystone trade sectors are endorsed by Solidary Systems.

1. **Health Sector**

   a. Community Emergency Response Team (CERT) (5 days)
   b. Community Health Worker (CHW) (8 days)
   c. Community First Responder (CFR) (8 days)
   d. Emergency Medical Technician-Basic (EMT-B) (3 months)
   e. Emergency Medical Technician-Intermediate (EMT-I)
   f. Emergency Medical Technician-Advanced (EMT-A)
   g. Emergency Medical Technician-Paramedic (EMT-P) (1 year)
   h. Emergency Medical Technician-Paramedic-Critical Care (EMT-P-CC)
   i. (1 year, 3 months)
   j. Paramedic Practitioner (PP) (2 years)
   k. Nurse (RN) (2 years, six months)
   l. Nurse Practitioner (NP) (3 years)
   m. Physician's Assistant (PA) (4 years)
   n. Physician (6 years)

   All modules post training level (PP) can acquire specializations via clinical/ didactic apprenticeships. None of the duration of trainings listed here include clinical preceptorship.

1. **Educational Sector**
   a. Kindergarten

b. Primary
c. Secondary
d. Tertiary
e. Vocational
f. Arts Education
g. Musical Education
h. Continuing Education
i. Special Needs/ Disability
j. Elderly Education
k. Distance Learning/ Home Schooling
l. Education Technology Development

1. Living Standards Sector

a. Construction Trades
b. Electrical Work
c. Plumbing
d. Carpentry
e. Welding & Metal Work
f. Restoration/Renovation/Rehabilitation
g. Civil Engineering
h. General Construction Trades

1. Livelihoods & Asset Management Sector

a. Accounting
b. Microfinance/ Microcredit
c. Small/ Medium Enterprises
d. Social Enterprises management
e. Cooperative Enterprise Management
f. Civil Service Enterprise Management

1. Civil Affairs Sector

a. Mediation
b. Negotiation
c. Contract Law
d. Human Rights Monitoring
e. Para-Legal Studies
f. Lawyer (JD)

g. Transitional Justice

1. **Emergency Response Sector**
   a. Fire Suppression
   b. Community Safety
   c. Peacekeeping
   d. Emergency Management

1. **Energy Resource Sector**
   a. Solar Energy
   b. Wind Energy
   c. Compost/ Bio-wastes Management
   d. Mechanical Energies
   e. Conservation Ecology

1. **Recycling & Sanitation Sector**
   a. Waste Management
   b. Salvage & Recycling
   c. Collection and Disposal logistics management
   d. Weather Mitigation Specialist
   e. Disaster Risk Reduction Specialist

1. **Communications & IT Sector**
   a. Information Technologist
   b. Telecommunications
   c. MESH Wireless
   d. Journalism & Print Media
   e. Video Journalism
   f. Radio Broadcast
   g. Investigatory Journalism

1. **Transport Logistics Sector**
   a. Motor Vehicle Operations
   b. Mechanics & Automotive Repair
   c. Livery & Public Transport Operations
   d. Public Transit Systems Design
   e. Dispatch Logistics

1. **Engineering Sector**
   a. Civil Engineering (Structures)
   b. Civil Engineering (Bridges)
   c. Civil Engineering (Tunnels)
   d. Civil Engineering (Electricity generation)
   e. Civil Engineering (Water Systems)

1. **Environmental Protection Sector**
   a. Hydrology & Water Services
   b. Agronomy & Agricultural Enhancement
   c. Ecological Services
   d. Sustainable Forestry
   e. Marine Conservation

Annex 2: Operational Timeline of EMS in Haiti

■ On January 12th, 2010 an earthquake of 7.0 Magnitude devastates Port au Prince, the Capital of Haiti. The estimated body count by the time the dust settles is between 260,000- 316,000 people. No one knows how many really died because no census had been taken due to anarchy and civil war after a coup in 2004. Since that time UN peacekeeper from MINUSTAH have occupied the country, despite to there being no declared ceasefire in the civil war between the elite and disbanded army; and the popular peasant movement Lavalas.

■ On January 15th, 104 medical volunteers depart to Haiti from JFK in an irregular medical column composed of EMTs, paramedics, RNS, and MDS from around the tristate area. This all civilian medical detachment is organized by **Bedford Stuyvesant Volunteer Ambulance Corps** under the command of Chief Jared Raeburn. It was supported by doctors and nurses from **Haitian Physicians Abroad (AMHE)** led by Dr. Louis August, Dr. Gary Jean-Baptiste, Dr. William Savoy & Dr. William Gibbs, and flown to Haiti on a Vision Airline Flight paid for by the **Church of Scientology**. Its composition was roughly 85% percent Haitian-American. 15%

was highly ethnically cross composed of EMTs, Paramedics and Firefighters from the tristate area**.**

■ January 16th, 2010 this civilian medical detachment arrives in Port-Au-Prince and is garrisoned in the Tabarre District of Port Au Prince. The compound is very rough and the next day they move their base to the Santo District.

■ January 17th, a negotiating team led by Dr. Louis August, Dr. William Savoy, and Dr. Williams Gibbs of AMHE meet with Haitian Health Minister Dr. Alexander Larsen and secure authorization to deploy the irregular medical column at the abandoned University General Hospital (HUEH) in the downtown area of the city.

■ The Bedstuy-AMHE medical column begins restoring functionality to the General Hospital (HUEH). They base themselves out of the triage building by the main gate caring for thousands of critically injured Haitian civilians. By nightfall they have re-established a 24 hour ER, an OB ward, a quartermaster depot and triage area.

■ January 18th: Around 6am a second 6.2 earthquake hits and the night crew must evacuate several hundred critically injured patients into the hospital yards already crowded with injured patients.

■ January 20th: EMT Adler, Paramedic Victor Cange, Dr. William Gibbs, and an Israeli Scientologist volunteer travel to Israeli Military Hospital and organize patient exchanges between the field hospital and the now operational General Hospital.

■ On Friday, January 22nd EMT Walter Adler, EMT Cassidy Vail, EMT Dominich Asbun, & EMT-P Victor Cange aided by several Haitian American EMTS began training a group of 100 Haitian nationals in basic first aid, lifting and carrying, and BLS skills. The leader of this group is a student named Gerard Prévot, his mother a nurse at the HUEH.

At their orientation on January 22nd, 2010 it was explained that the immediate objective of the program was assist in the relief effort then ongoing. The secondary objective would be to establish an internationally recognized EMS program and for this to serve as the nucleus of Haiti's first Emergency Medical Service.

The meeting was attended by roughly 100 Haitians, translated in full every five words into Creole and had a three hour question period. It was explicitly explained there would be **no pay** to

participate in the program and **no guaranteed jobs** after.

■ On Sunday January 24th, the first official training occurred and was attended by over 500 participants. They began to drill a group of approximately 500 Haitian nationals in first aid and basic life support skills under the auspices of an ad-hock EMS training program called Unit C.

This formation drew volunteers from a wide range of social networks concentrated around the General Hospital in the weeks immediately following the earthquake. Its primary organizers were young bilingual Haitians from middle class church associations, student groups and youth scouts, as well as medical students and employees of existing NGOs.

■ By March 2010 participants in UNIT C declare the **Gwoup Ayisyen pou Ijans-Haitian Emergency Group (G.A.I-H.E.G.)**. Working off a list of the most dedicated volunteers they began drilling in acquired skills with help from the **Canadian Red Cross** and **IsraAid.** Working in coordination with first wave rescuers they received training and organizational materials in French.

■ In May 2010 via coordination online of an Alliance begins to develop between first wave rescuers represented by the **Banshee Association**, a newly formed NGO **called Lend a Hand and Foot (L.A.H.A.F.)**, the cowboy EMS outfit in Haiti the **Material Management Relief Corps (M.M.R.C.)** and the **G.A.I.-H.E.G.**

■ July, 2010: EMT Walter Adler & EMT Dave Briscoe representing the Banshee EMS Association and Louis August Jr. and Jennifer Slitter representing Lend a Hand and Foot (LAHAF) agree to a redeployment of EMS to Haiti for the earthquakes second anniversary to train the cluster of EMS volunteers of the G.AI. August will provide a training base in Haiti. Slitter will organize publicity. Adler and Banshee Association will recruit the personnel.

■ September, 2010: Logistics of deployment are agreed upon by G.A.I., L.A.H.A.F., M.M.R.C. and BANSHEE. WEMT-P Michael Mastroianni and WEMT-P Peter Taft are selected as Deployment commanders. Both as Wilderness Paramedics and certified instructors have extensive experience training EMS abroad and working in disaster zones. Taft was a leader during the Second Wave of the Bedstuy deployment.

Both are directly recruited by Banshee Association along with roughly 40 other EMS, media and civilian support volunteers from NYC, Miami, and Las Vegas.

■ November 5th-7th, 2011 Banshee holds a Congress in Upstate NY to finalize the planning details for the Haiti EMS training operation set to begin on January 5h, 2011.

Banshee Association was responsible for developing the logistics of the redeployment known as the 'Volunteer Conduit'. They also set out to recruit forty medical volunteers for redeployment, largely fire fighters, EMTs, paramedics, and support personnel from Chicago, New York, Miami, and Las Vegas.

Banshee also undertook the financing of the operation throwing several large events. It sponsored an equipment drive raising approximately $5,000.00 in reusable medical equipment. It also deployed an embedded film team to document the deployment and the effort to train the G.A.I.

Footage has been shot from three months before deployment as well as the first month on the ground. The GAI has been supplied with a video camera and further filming has been done by Banshee film maker Justin Thomas.

MMRC took responsibility to develop a training curriculum and providing instructors. The point people for that effort were EMT-B Paul Sebring and EMT-B Kay Byers.

LAHAF took responsibility to house, feed and transport volunteers. It also brought in WEMT-P Instructor Michael Mastroianni to design a volunteer orientation, fine tune the MMRC curriculum and handle safety and security while in Haiti.

Volunteer teams would deploy for 1-3 weeks in waves to sustain an EMS training program at base in the neighborhood of 75 Delmas provided by LAHAF after the MMRC base was lost due to logistical and security considerations.

GAI-HEG was responsible for marshaling the volunteers and ensuring they attend the courses offered.

■ November7th-December 25th: $5,000.00 in medical training supplies is raised via the Banshee Newspaper and an online supply drive. 29 medical, civilian and media volunteers had bought plane tickets to Haiti and are set to drill roughly 60 GAI members for four weeks, then continue the program if the first four weeks are successful. Anticipating good press and an influx of volunteers after the first four weeks, the pilot training program is extended 8 weeks.

■ January 5th, an advance Team led by WEMT-P Michael Mastroianni and EMT Kate Hanselman arrives in Haiti. Deployment Commander/ Chief Medical Officer Michael Mastroianni begins set up at base at Delmas 75. It is also the *USFilmAid* office.

It is a three story building in a gated compound with no security. It has 2 bedrooms (one locked), kitchen, bathroom, mac desktop sound and video equipment. The compound is owned by Lou August Jr.'s Aunt. A man named Tifway a 25 y/o male, speaking limited English lives there as a caretaker with his family of two and Haitian Nationals Samuel and Carlos work there for US FilmAid. There is 10 passenger van with 2 flat tires, engine didn't start. There was little to no food on hand.

■ On January 8th Nick Rosenbaum, Banshee Logistics Officer arrived in Port Au Prince along with Clancy Nolan a journalist. They are picked up at airport by a man named Ronald. Lou Auguste Jr. arrives early January 9th.

The advance team begins building benches for students out of salvaged wood and readying the compound. Shopping was done at Eagle Mart, where it is over-priced and geared for NGOs and UN Staff. The Van is repaired.

■ Wave 02 officially begins (January 9th, 2011)
Group A: EMT-P Victor Cange, Matt Mallon (CPR instruction), Film maker Ryder Haske, Film maker Nick Bruckman, Jon Denby (Photographer), Marianna Marisova (Photographer) . Emma Sacks (PhD Public Health) .

All are stuck at airport and couldn't get a ride because the LAHAF Van broke down enroot. Stranded at airport, eventually they take a *Taptap* to Delmas 75 base.

■ Monday January 10th, registration officially begins. Approx.: 60 GAI members arrive.

■ Wednesday January 12th. Emma Sacks MPH begins to provide training in Cholera treatment and prevention. This program is endorsed and certified by the Haitian Health Ministry the MSPP. There are also some rotations done in HUEH as well as s few camps by American EMS volunteers.

Cholera Prevention training begins Wednesday, tested with a print-out multiple choice French test. 45 Haitians in GAI are certified.

Nightly meetings and trainings were regularly filmed. Extensive testing and documentation of GAIs ability carried out.

■ Thursday, January 13th, EMT Virginia Byers and RN Bridget Mulrooney from MMRC arrives with EMS lesson plan.

■ Group B begins arriving January 14th: They are all paramedics from Miami who met Cange and Adler during the original deployment after the quake. In January of 2010 they had self-deployed to Haiti, crossed from the Dominican Republic and were running an ambulance out of a bread truck by day 3 of the relief effort.

EMT-P Eric Alvarez, EMT-P Yosel Garcia, and EMT-P Michael Bello.

■ January 15th: Filmmakers Alexander Greenlee & Andrew Fishman arrive to join the Media Team led by Ryder Haske, and relieve Denby, Bruckman, and Marisova.
WAEMT-P Peter Taft takes over from WAEMT-P Michael Mastroianni as Deployment commander.

■ January 16th: Election Day rioting begins over allegations of fraud and exclusion of Michel Martelly and the return of former dictator Francois Duvalier J r. He is arrested at airport. Violence erupts between protesters of varying political factions and the MINUSTA soldiers attempting to keep order.

■ January 21st Group C arrives
EMT-I Tim Sullivan, EMT-B Kate Sullivan, film maker and photographer Jon Resnick.
Still remaining on the ground are Greenlee, Ryder, Sarah Schlesinger (speaks French and did a lot of translation).

■ January 27th Group D arrives:
LAHAF coordinators Sonia Miranda and Jennifer Slitter arrive.

In NYC Banshee Association throws another gala at the Living Theatre to raise money for supplies, provisions and compound rent.

■ February 3rd WEMT-P Howard s recruited by LAHAF to keep school running Brought in by Jen. Paramedic. His previous experience includes high value asset protection work in Latin American and EMS instruction abroad. Still on ground until WEMT-P Howard takes over:

Ryder Haske shooting footage of operation until Howard pulls out with Nick Rosenbaum Feb 3rd. RN Bridget Mulrooney stays on a week longer. By March no foreign volunteers in country except Howard who continues GAI class at Delmas 75 six days a week, four hours a day until July 25th, 2011.

Everyone who came back, came back enthused about program but highly aware of the difficulty of our mostly all civilian grassroots effort.

■ Between July and August of 2011, G.A.I. officially joins the Health Cluster and attempts to build relationships with various NGOs in Port Au Prince. See attached allies sheet. Particularly Haitian Red Cross, International Medical Corps and Partners in Health. They complain that no one takes them seriously because they are all Haitian and very young. Median GAI age is about 22 years old, no members are younger than 18. Also they all work and go to school so it is hard for them to organize. LAHAF and BANSHEE continue to support GAI with online trainings and advice, as well as evaluate how to proceed efficiently. LAHAF achieves 501 C 3 status and focuses on backend negotiations with Health Cluster, MSPP, and the Clinton foundation.

Banshee focuses on broadening its human resource pool and building with the NYC Haitian community.

■ September 2011: Banshee codifies "Alliance01 Framework", a resource sharing clearinghouse for all groups working on human rights centered activities.

■ EMPACT Northwest and Project Medishare graduate a class of 14 Haitian EMTs.

■ October 2011: Alliance01 begins meeting to organize a limited deployment and resupply of GAI in January 2012. Ideas are circulated and discussed on holding a mock practical exam witnessed by NGOs and MSPP to prove GAI can pass a French language BLS exam. The plan involves filming the exam and then presenting it and the witnesses as evidence to the MSPP of GAI medical proficiency. Then, lobbying the Haitian community to bolster and expand the EMS program once these men and women are in the field.

■ November 2011: Alliance01 reconstitutes Banshee Association's Supply & Logistics Working Group, Finance Working Group, and Medical Instructional Working Group.

■ December 13th, 2011, Specialist Wilkinson Francois, Banshee member and specialist of the US Military arrives Haiti stays with Gerard from 12/13/11-12/23/11.

His impressions of G.A.I.:

They are dedicated. However, they lack serious organization tactically or administratively. Gerard Prévot and a few other leaders do most of the organizing and do not yet empower a secondary leadership. Members appear highly motivated and capable at performing EMS skills, but they are in need of a command structure. Regular meetings and drills hold the group together, although their social network is what has sustained this more than any unified vision or organizational structure. Which they lack but are eager to learn.

They are holding regular meetings with twenty or more in attendance. I gave a talk on 'American mentality', helping G.A.I. to better understand our capabilities and cultural differences. He also clarified political and administrative differences of approach in Alliance01, especially between LAHAF, MMRC, and Banshee.

A lot of their complaints have to do with problems of communication, funding, safety and respect.

Few organizers other than Wilkinson, Cange and Adler from Banshee and Erek Tinker from LAHAF have been in regular contact with them. Only Gerard and his sister, co-founder Geraldine speak English fluently.

They all study and work part time, so their time is limited and increasing frustration grows over a) no certification and b) little support from other NGOs. They are however registered an official organization in Haiti via the Social Ministry and are participating in the MSPP facilitated Health Cluster.

Many felt their lives would be in jeopardy to practice EMS without MSPP certification and aid from a larger Haitian group on the ground.

They often felt, especially in dealings with WEMT-P Howard and various non-EMS personnel that they were being disrespected, treated like 'children & students' and not as professionals and change makers.

They felt the language and cultural barriers made it hard to connect with the foreign volunteers, and that while they were highly grateful for the 6 months of training and all the supplies; they wished volunteers had connected with them further as human beings outside the classroom. This

was not across the board, but in particular they were disappointed that after two years of work there is still no MSPP certification or an immediate likelihood of employment as EMTs.

GAI lacks has often lacked a fixed base. They have held salons (dinner party discussions) at various homes to develop their vision as a group. They have also produced a Declaration Statement (see attached).

They have also been meeting and drilling regularly at the Rue Laraque & College Fleurantin. They have also acquired an abandoned property on Delmas 32 and base with the FRAED Haitian MD organization at Delmas 33. It lacks a roof but can be used as a training ground. There's some reason to think this property can be easily refurbished for at least some purpose.

WEMT-P Howard (via LAHAF) was running the GAI EMS program from mid-February-July 25th, 2011. He ran it very paramilitary and often was perceived as somewhat disrespectful in his military cadence. He did rigorous testing and threw out about 35 GAI members who were unable to always attend due to other school and work. He graduated 25 and gave them a test in mid-July.

Re-Occurring GAI questions were:

"How much longer do they have to wait for certification?" and "will there ever be paid work as an EMT in Port Au Prince". They also sought clarification on components of the Alliance01, and if this Alliance will sustain support and send more volunteers soon.

Wilkinson clarified who is who in LAHAF, Banshee Association & MMRC and helped them understand the staff breakdowns of labor and support.

Gerard lives in Carfoure-Fuille, most of his members live in Delmas. Gerard and his team have poor compartmentalization of labor, or specialization of task. It looks as though Gerard Prevot has laid quite a lot of ground work with the help of his team however they are not organized well as group. There is obvious centralization of command with about 8 leaders, but Gerard and his sister Geraldine have done most of the hard organizing and attendance of official meetings with Health Custer, the primary Port Au Prince medical clearing house.

The following are operational questions posed to GAI-HEG by Banshee Association delegates Adler, Rosenbaum & Briscoe in September 2011:

1. How many active members do you have in total, including non-medical members, semi-trained medical members, and active organizers?

GAI reported: See attached spreadsheet roster.

28 trained EMT-Bs. 35 First Responders, semi-trained in a wide range of medical professions. 16 non-medical members that aid with organizing.

Total strength: 76 part time members, approximately 25 active members.

2. How many members do you have with Cholera prevention certified by the Health Ministry?

45. All have official MSPP documentation.

3. How many members have completed the BANSHEE-LAHAF EMT Pilot Program?

25. Out of 60 who began it.

4. How many members could realistically pass an EMT-B exam in French?

45.

5. How many members speak English?

3.

6. How many members speak Spanish?

3.

7. What equipment does G.A.I. still have on hand:

Virtually none. Several dozen uniforms. Several dozen sets of diagnostic equipment. A range of French language EMS materials. A single long board.

8. Has G.A.I. fully implemented NIMS, and who are the eight primary officers?

No. GAI does not understand how to use NIMS or know what structure will be most effective.

9. Does G.A.I. have a supply depot where equipment can be secured and where is it?

Yes. A secure base has been given to us just to store equipment. It is in Carrefour-Feuille. A second is on Delmas 35.

10. Has GAI drafted a MISSION STATEMENT or OPERATIONAL BILAWS?

A mission statement of two pages articulating why GAI exists and what is its long term/ short term aim has been collectively written (see attached).

OPERATIONAL BILAWS are not codified, understandable chain of command, protocols for operations and procedures have not been written.

11. Does GAI have weekly meetings, how often and where?

Yes. Now, for the project, we use to meet at least twice a week. At Rue Laraque. College Fleurantin.

12. Does GAI have leadership meetings, how often and where?

Yes. We also meet at the same local and at least twice a week and we also communicate by phone.

13. Does GAI have weekly drill for members to practice EMS skills, how often, how long, and where?

In the past, yes, but not now, because all our members are working together to make the current project a success. But we also make some extras class for the new and semi-trained members once a week.

14. Does GAI have a central base, functional command center in a storm/flood/quake/unrest/emergency?

Yes, we have one, not our own. We can still meet there but cannot make it our own functional

command center.
15. Does GAI have a deployment plan for storm/flood/quake/unrest/emergency?

Yes, we do. Because depending on the structure of G.A.I, we have a specific group of people for each event.

16. Have you Surveyed AND LIST ALL FUCNTIONAL/ SEMI-FUNCTIONAL receiving medical facilities in the vicinity of PAP. Please list a contact person for each, how many hours a day they operate, who runs them, and funds/supplies them.

Yes. See attached.

17. Who have you contacted in the Haitian Health Ministry MSPP?
We have direct contact with Health Minister. We participate in the Health Cluster and have close ties with Haitian Red Cross and others. We have met with Dr. Claude Surena of MSPP.

18. Who have you contacted in the Partners in Health organization?
Worked with them in Health Cluster, no formal alliance.

19. Who have you contacted in the Haitian police force?

No one. (GAI would later go on to begin actively training the HNP in first aid skills with St. Jeans)

20. Who have you contacted in JP-HRO?

We are not formal partners, but we use to make drills for the people in the refugee camp they are based at Petionville Club. But we have done volunteer rotations in Petionville Club Camp. JP HRPRO would emerge later as clinical site and EMT employers sending its employees to both classes 03 and 04.

21. Who have you contacted in the Church/Catholic community?

Several churches have hosted our educational activities.

22. Have you contacted in the Haitian Red Cross?

Yes we have met with them about skill sharing workshops.

23. Who have you contacted in Grass Roots United?

No formal alliance.

24. Who have you contacted in Haiti Village Health Project?

No contact, they are based in Cap Haitian.

25. Who have you contacted at University Hospital? (HUEH)

We have a relationship beginning with the International Medical Corps based there.

27. Who have you contacted at MEDISHARE Hospital?

No.

28. HAVE YOU DIVIDED PAP INTO OPERATION DIVISIONS?

Yes. We've done it depending on where each member is located. We have three divisions: Delmas Lower, Le Vil and Carfour Feulle.

Specialist Wilkinson Francois has helped secure two serious potential allies for GAI:

F.R.A.E.D.:

They are church based organization that provides organizational support and legal aid led by former Haitian Judge Dr. Ronald at a center on Delmas 33. They have given free access to GAI. And are interested in hosting meetings, giving office space and a supplies base.

Haitian Red Cross: Is providing water purification training. Based in downtown area. They wish to help GAI and host foreign medical volunteers if their members can get EMS training.

International Medical Corps is funding IMC to be at HUEH, providing training medical training in general.

They have given GAI EMS training materials in French.

World Food Program: Feeding Haitian EMS upon receipt of program of instructions (POI)

Global DIRT: We will be asking for witnesses and their aid running our practical skill stations.

JP-HRO: We will be asking for approval for GAI to do clinical rotations.

Health Cluster: Will be asking for representation.

■ On January 4th, 2012 EMT Walter Adler and EMT-P Victor Cange deploy to Haiti to drill GAI in EMT-B practical skills and admin French language written exams. They bring with them 2 long boards and 300ibs od BLS equipment.
They also helped them develop a strategy and an organizational structure best suited to their work and implement NIMS command system.
They negotiated directly with MSPP and NGOs to provide material support and guidance to GAI, Haiti's first volunteer EMS organization.

■ January 12th, delegates from EMPACT Northwest, EMAPCT Haiti, GAI, Global DIRT and Banshee meet at the hotel Olofsen for a triparte discussion on EMS in Haiti.

■ On January 22nd WEMT-P Michael Mastroianni, WEMT-P Howard and EMT Adler organized and a witnessed EMT-B exam and practical skills test for the GAI. It included 5 Practical Skill Stations supervised by Haitian MDs from FRAED and an 125 question BLS Exam in French. It was filmed as evidence that GAI is medically competent and ready to serve the people of Haiti. It was witnessed by HAC, Empact Northwest, PIH-ZL, FRAED, and JP-HRO.

■ All 29 GAI members pass the written with an average of 87% (tests on file) and all pass the practical skill stations. Two years to the day of their creation, Gerard and Geraldine Prévot read the "Declaration of the GAI" to those in attendance.

■ On January 26th, 2012 EMPACT Northwest calls an EMS Consortium together at the Foursquare Church to unite the various EMS efforts in Haiti.

■ February Dr. Ginzberg of Project Medishare, representing the EMS initiatives under the RMA umbrella meets with President Martelly about the project.

■ Febraury 19th-22nd 16 EMT members of the GAI and 8 members of Global DIRT cover the Haitian Karnival in Less Cayes.
■ March 13th, 2012 EMPACT and Banshee Association meet in New York to sign a mutual aid agreement.
■ April 1st, a third EMS Class begins taught by Banshee, EMPACT, EMPACT Haiti and GAI instructors in Commune Priener. This is the first class taught by Haitian instructors in French and Creole using French power points.

■ April 4th: Banshee Association volunteers supply the GAI with another 300 IBS of BLS Medical equipment.

■ April 13th: Banshee Association, GAI, EMPACT, and Haitian American Caucus meet to discuss RMA Framework and mutual aid agreements between groups.

■ May 5th: Banshee and GAI submit drafts of RMA Joint Statement and Structure to be evaluated by the other allies.

■ May 20th GAI graduates a class of 100 first responders using the St. John's Ambulance first aid course.

■ Out of 29 initial students, 26 graduate on May 25th, 2012 bringing total number of Haitian EMS up to 68 EMTs

■ May 25th: Dr. Ginzberg of Project Medishare meets again with President Martelly to present the EMPACT EMS curriculum.

■ May 30th: GAI and HAC begin a first responders course in Croix de Bouquet.

■ June 1st: Project Hope and Global DIRT begin emergency responder courses via moto bike at their respective bases.

■ RMA Allies continue sending EMS volunteers and BLS equipment to Haiti until the time an EMT certificate is recognized by MSPP and funded to stand efficiently as Haiti's first public EMS system.

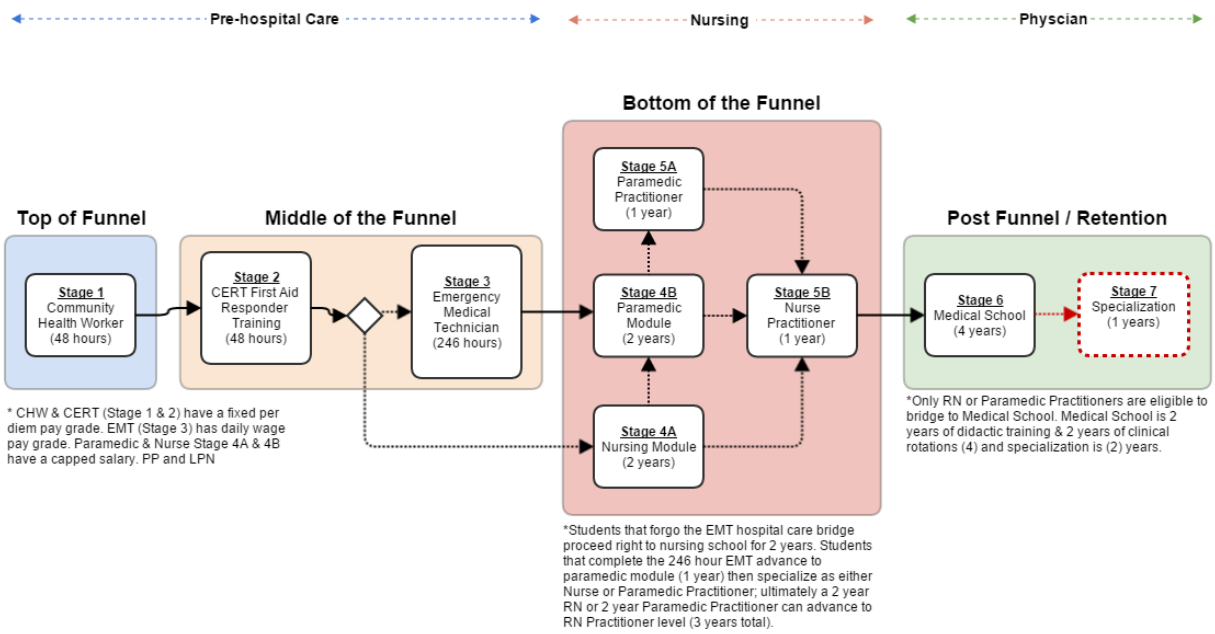
■ From June until September 2014 the RMA 0004 Class successfully graduates 36 more EMTs at the HAC base in Croix des Bouquets bringing total cohort to 104.

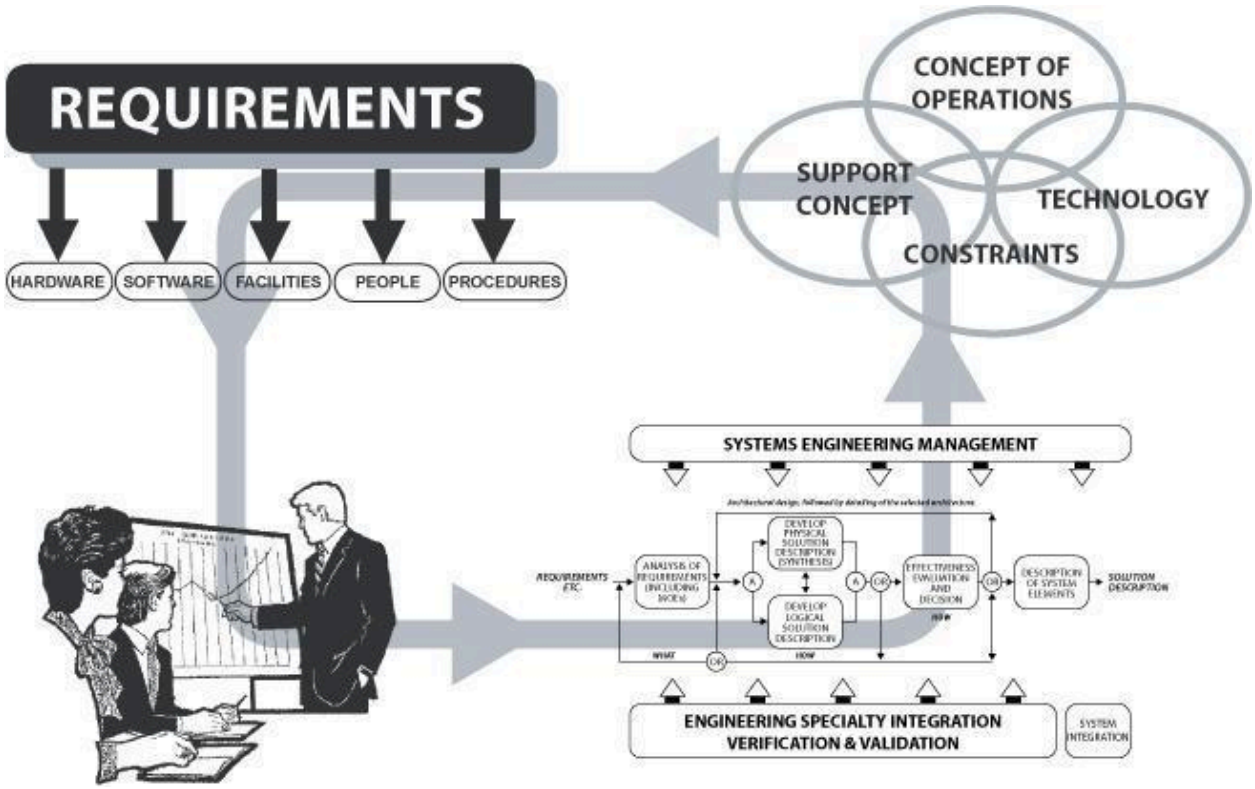
■ In November 2014 Physicians for Haiti invites GAI to address their conference in Haitian on healthcare entrepreneurship

■ In December 2014 P4H MDs begin discussing the possibility of codifying and presenting some prehospital care protocols to the MSPP.

Annex 3: Map of Haiti

Annex 4: Fully Integrated Health System




REQUIREMENTS
HARDWARE
SOFTWARE
FACILITIES
PEOPLE
PROCEDURES
CONCEPT OF OPERATIONS
SUPPORT CONCEPT
TECHNOLOGY
CONSTRAINTS
SYSTEMS ENGINEERING MANAGEMENT
ENGINEERING SPECIALTY INTEGRATION
VERIFICATION & VALIDATION
SYSTEM INTEGRATION